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ABSTRACT

A study examined institutional influences on the instructional planning decisions of nurse-academics presenting basic nursing curricula in colleges of advanced education (CAEs) in New South Wales. Data were collected from the following sources: survey of 86 selected nurse-academics from 12 of New South Wales' 15 tertiary institutions running basic nursing courses; interviews with 14 nurse academics lecturing at 4 colleges that were selected as being representative of New South Wales' CAEs; and observations of 54 hours of classroom instruction delivered by the lecturers interviewed. Of the 86 nurses surveyed, 66 (77%) completed questionnaires. Cross-tabulations and t-tests were used to determine the results' significance and identify trends in the data. Factors related to time, money, and workload and physical characteristics of the teaching environment proved the most constraining influences on nurse-academics' instructional planning decisions. The following factors were determined to be the strongest facilitators: department head's philosophies of education and nursing and management style; lecturers' areas of special expertise; and philosophy of the college. It was recommended that nursing education department heads develop mechanisms for nurse-academics to maintain their clinical experience and find ways to reduce nurse-academics' workloads. Contains 15 tables, 4 figures, and 34 references. The questionnaire is appended. (MN)

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INSTITUTIONAL INFLUENCES ON NURSE-ACADEMICS' INSTRUCTIONAL PLANNING DECISIONS IN THE IMPLEMENTATION OF BASIC NURSING CURRICULA IN COLLEGES OF ADVANCED EDUCATION IN NEW SOUTH WALES

by

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This study is dedicated to the nurse-educators of New South Wales who undertook to change nursing education by transferring nursing education programs to the tertiary education sector and in the process became nurse-academics,

and

to the nurses who instigated the movement of Australian nursing education to the tertiary sector and worked tirelessly to make it all possible,

and

to the individual nurse-academics who contributed their precious time to assist me in this work and without whom this study would not have been done.

ABSTRACT

This study shows the influences on instructional planning decisions of nurse-academics in colleges of advanced education in New South Wales. Questionnaires which comprised The Roberts Scales were administered to nurse academics in 12 C.A.E.'s in N.S.W. Fourteen nurse-academics in four C.A.E.'s were interviewed. Cross-tabulations, t-tests, cross-correlations and breakdown procedures were used to determine the significance of the results and identify trends in the data. Transcripts of the interviews were analyzed for significant themes. The major constraining influences were funding, the workload and the lack of time in the course. The physical characteristics of the teaching environment were also constraining. Major facilitating influences were interpersonal relationships with colleagues. Facilitating factor theory is introduced. Recommendations are made for action by the Government and Heads of the nursing departments of C.A.E.'s in New South Wales.

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CHAPTER I

INTRODUCTION

1.1 Background to the Research

In 1983, the Minister for Health in New South Wales (N. S. W) announced a major change for nursing education, namely the transfer of basic nursing education courses into the college of advanced education (C.A.E.) sector. In N.S.W., the rest of the C.A.E. programs began in 1985 and hospital-based basic nursing programs were phased out by 1988. Nursing education was to be funded mainly by State Government funds until the end of 1993 when the Federal Government was expected to assume the complete responsibility. The last hospital nursing intakes anywhere in Australia were in 1990. At the time of the study, 38 basic nursing courses in universities and C.A.E.'s had been registered with the Australian Council of Tertiary Awards (A.C.T.A.,1988:89). Additionally, 15 institutions offered post-registration degree conversion courses, 7 offered graduate diplomas in clinical nursing, 6 offered a master's degree and 2 offered a Ph.D. (A.C.T.A., 1988:89).

A period of development and expansion of tertiary nursing education programs began in 1984. Nursing brought 6,000 students and millions of dollars into the C.A.E.'s, which welcomed this expansion after a period of limited growth. The exact figures are not available for the amount of capital infused into the tertiary education sector by the N.S.W. government to finance the inception of nursing programs; however there have been 6500 students funded and the Commonwealth Government expected that $8000 per student would be expended in the form of capital development (personal communication with Department of Health and the Office of Higher Education). Thus, the transfer of nursing education into the tertiary sector would have initiated an injection of funds of approximately $50 million. This expenditure took the form of both money and 'assets in kind' such as space in hospitals reserved for the college students, and buildings such as office accommodation in former nurses' residences. Additionally, the recurrent expenditure per year was of the order of $45 million. A State Planning Committee with representatives from Health and Education Ministries was set up to oversee the transfer and allocate the initial funds for development of the courses. The new nurse-academic positions were mostly filled by recruitment of nurse-teachers from hospital schools.

As the colleges began to plan for the introduction of nursing courses, each developed its own course curriculum. As Pilkington (1986:1) stated:

> *The introduction of basic nurse education within the college sector has allowed the deregulation of curricula. Each college has been able to design a curriculum in keeping with the philosophy of that college. While this has brought much freedom to nurse-academics in that they have been able to implement ideals and philosophies which have developed as a result of years of experience, it has also meant that issues have arisen which in many instances have not been envisaged.*

This study concerned the nurse-academics' curriculum decision-making in the early stages of implementing the new college curricula. It also concerned the many issues which have arisen in the course of implementing the most significant change in nursing education in Australia in the last century.

1.2 Context of the Problem

The research problem concerned influences on nurse-academics' curriculum decision-making in tertiary education institutions. For the purposes of this study, curriculum means a 'plan for providing sets of learning opportunities to achieve broad goals and related specific objectives for an identifiable population' (Saylor and Alexander 1974:6). According to Bevis (1978:8) a nursing curriculum is:

> *the holistic manifestation of many composite parts and factors which together enable the achievement of nursing educational goals that have been carefully identified, selected, and articulated.*

All teachers make decisions about the curriculum. A decision is a 'choice made by persons for action' (Harrison, 1978:26). Decision-making is 'the making of reasoned choices from among several alternatives' (Cassidy and Kurfman, 1977:1). Curriculum decisions are influenced by constraints which define the teacher's 'room to move', or decision-making space (Bernstein, 1971:50; Smith, 1983:21). Knopke and Diekelmann (1978:35) have stated that in managing a nursing course, teachers must identify factors such as student characteristics, the amount of time in the course and the relative availability of teaching resources and finances, which may act as constraints.

1.3 Purposes of the Study

The main purposes of this study were:

1. To elucidate nurse-academics' perceptions of the effects of influences of the institutions in which they teach on their instructional planning decisions in the C.A.E. basic nursing education programs.

2. To test frame factor theory.

3. To expand frame factor theory to include facilitating as well as frame factors.

4. To determine issues concerning the implementation of the new nursing curricula in order to contribute to the understanding of the evolution of nursing education in N.S.W.

1.4 Frame Factor Theory

Frame factor theory may be used to explain the influences under which curriculum decisions are made. It is an explanatory level theory which suggests that teachers are constrained by frames or sets of factors that limit their decisions. Frame factor theory was originated in the 1970's by Bernstein (1971) and developed by Dahllöf (1971) and Kallós and Lundgren

(1976,1977,1979). Bernstein originated the idea of frame in pedagogy:

> *Frame refers to the specific pedagogical relationship of teacher and taught ... Frame refers to the strength of the boundary between what may be transmitted and what may not be transmitted, in the pedagogical relationship. ... Frame refers to the degree of control teacher and pupil possess over the selection, organization and pacing of the knowledge transmitted and received in the pedagogical relationship (Bernstein, 1971:50).*

1.4.1 Theory-generating Studies

The early theory-generating studies of Dahllöf (1971), Kallós and Lundgren (1976) were concerned with interactive decision-making. Dahllöf stated:

> *Frame factors have in common that they set certain time and space limits to that part of the educational process that takes place at the school (Dahllöf 1971:75).*

He suggested that frames could be either fixed or able to be manipulated. He stated that the general, economic and cultural aspects of the environment were 'a fixed feature of the school system that cannot within a reasonable time be subject to change and in any case not by the school authorities'. The immediate background for teaching situations consisted of factors that were able to be manipulated or were under the control of the school system, or possibly the teacher, at least in principle. Thus, there were frames or broad areas of constraint, which were made up of individual components called frame factors.

Dahllöf (1971) studied ability grouping and content validity in secondary schools in Sweden in the 'sixties. He found that teachers' decisions were limited by frame factors or 'such characteristics of the environment in which the instruction is going to take place that are under direct control by the school authorities' (Dahllöf, 1971:75). Dahllöf found that there were physical frames, for example, the size and structure of school buildings, and administrative frames for example, length of school year and day, and ability grouping of students (Dahllöf,1971:75). Dahllöf(1978:33). suggested that the physical characteristics, administrative factors and teacher characteristics were within the frames able to be manipulated. He also suggested that recommendations about content and methods could function as frames, as could textbooks and teaching aids (Dahllöf, 1978:51).
The model that Dahllöf developed included other frame factors such as total time at the disposal of the teacher, teacher utilization, access to teaching aids, localities, and location in the community. He distinguished these frame factors from general environmental factors, individual factors of teachers and pupils, for example repertoire of teaching patterns, and curriculum process factors, for example time for teaching the content. According to Lundgren (1981:198), Dahllöf's extension of the concept of frame to factors outside the teacher and student's control links the macro, or societal, and micro, or school, levels of analysis.

Lundgren (1972) carried out a comprehensive study of pedagogical processes in academic high schools in Sweden by means of questionnaires and classroom observation. He noted that planning guides, textbooks, principals, local consultants, expert teachers, central consultant teachers and local planning groups were all sources of influence on teacher curriculum planning. He found that the curriculum and textbook were of the greatest importance for pedagogical planning (Lundgren, 1972:145). He also found that the composition of the class clearly influenced the teaching process and that in each class there was a 'steering group' that set the pace of teaching and governed the amount of information the teacher could transmit Lundgren (1972:339).

Lundgren also noted that 'the teaching process is not only steered by the frames, but also limited by them' (Lundgren, 1972:13). He stated that Bernstein's original concept of frame was limited

to constraints on content, but that 'in a broader sense, the number of options as to the form of transaction, the methods devoted to a certain subject (or content unit) during a definable period ... could be regarded as limited, or framed' (Lundgren, 1981:198). He also identified recommendations about goals, content, time and composition of the class as factors that could frame the teaching process (Lundgren, 1972:12). He stated that the composition of the class and the time available were the main frames for the teaching process (Lundgren, 1972:13).

Kallós and Lundgren (1976:8) expanded the concept of frame. They introduced an organizational frame, referring to decisions about the composition and grouping of the class. They also introduced a personal frame, referring to the decisions about the assignment of a particular teacher to a particular group of students. They also stated that pedagogical decisions are 'constrained and to a certain degree also directed by the regulations imposed by and decisions made at other levels' (Kallós and Lundgren, 1976:6). They suggested that framing may be decided upon and introduced at various levels of the educational bureaucracy. They also suggested that fiscal decisions above the school level have considerable impact on teaching decisions (Kallós and Lundgren, 1976:6). They introduced the notion of higher order and proximal frames (Kallós and Lundgren, 1976:22). Proximal frame factors 'define the space of options and form the immediate basis for the instructional planning by teachers' (Kallós and Lundgren, 1979:30). At the same time:

> *The concept of frame ... does not merely provide a tool for the description of actual decisions taken, nor does it only serve as a concept that can be used in order to describe what is actually stated in relation to curriculum, teaching, and the educational system. ... Framing denotes certain observable aspects of the educational system (Kallós and Lundgren, 1976:30).*

They stated that frames have 'constraining and directive' effects on pedagogical activities (Kallós and Lundgren, 1979:30).

Lundgren (1981:198) also distinguished between factors that constrain the teaching process and factors that govern it. He stated that frame should only be used for factors that constrain the process. He included among factors that govern the process the curriculum and its products and the legislative system regulating the teachers' duties.

1.4.2 Frame Strength and Size

The notion of frame strength was introduced by Bernstein (1971:50), who stated:

> *Frame refers to the strength of the boundary between what may be transmitted and what may not be transmitted, in the pedagogical relationship. Where framing is strong, there is a sharp boundary, where framing is weak, a blurred boundary between what may and may not be transmitted. Frame refers to the range of options available to teacher and taught in the control of what is transmitted and received in the context of the pedagogical relationship. Strong framing entails reduced options; weak framing entails a range of options.*

The concept of frame 'concerns the mechanisms of decisions and control in the establishment of strong (or weak) ... framing' (Kallós and Lundgren, 1976:17). This issue was related to the functions of educational systems. Frame strength has come to mean 'the degree to which a frame is perceived by a teacher as able to be changed' (Smith, 1984:242). In a study of seven primary and secondary school teachers, Smith (1984) investigated the influence of frames on teachers' curriculum decisions at the lesson planning level. He used an ethnographic methodology to study the influences and extended the concept of frame to include decision-making space.

The size of the frame is determined by the closeness of the boundary to the teacher. It is affected by two main factors: the number of curriculum decisions that a teacher believes have already

been made by other persons or agencies and the number of potential choices available for each of the decisions to be made by the teacher (Smith, 1983:22). That is, the more decisions the teacher believes have already been made by others, and the fewer choices available for a given decision, the smaller will be the perceived frame size.

1.4.3 Decision-making Space

The notion of decision-making space was originated by Kallós and Lundgren (1979:32):

Frames define an operating space for planning and subsequent actions by teacher and students. The uses of that space are dependent upon the teacher's perception of the proximal frames, his ideas about teaching (which in their turn are to some extent shaped by the frames) and his knowledge of different courses of action.

Frame factors and the operating space have been investigated by Smith (1984). Smith extended the concept of the fixity of frames or their ability to be manipulated to include the perceived decision-making space, i.e. the teacher's 'room to move'. The teacher's total curriculum decision-making space results from interaction of a number of individual frame spaces which represent:

> *the degree of freedom or restriction of a teacher's curriculum decision-making provided by the policies, decisions and behaviour of people external to the teacher, operating at a particular level, or in a particular context of the schooling system (Smith, 1984:239).*

The number of options can be limited by the perceptions of the decision-maker, and the total space is framed by a kind of minimum boundary (Maxwell, 1985:48).

The concept of perceived curriculum decision-making space extends the concept of frame by encompassing all curriculum decisions, emphasizing the nature of the space rather than the frame, suggesting factors responsible for size of frame and frame space, showing how the frame can be altered, and showing that frame or frame space depends entirely upon teachers' perceptions (Smith, 1984:237). Furthermore, each frame space is defined by a structural element of the schooling system, such as the organization of the school, which limits the teacher's curriculum decision-making space. The teacher's own perception of the frame may be more important than the objective size and strength of the frame (Smith, 1983:22). The predominance of the perception rather than the objective reality of the frame is supported by Cohen and Harrison (1982) in the findings of the Curriculum Action Project (CAP).

1.5 Facilitating Factor Theory

Although there had been a considerable amount of development of frame factor theory, it seemed to the researcher that constraints were only half of the story. It followed that there would also be factors that would facilitate the decision-making process. Earlier, Klein, Tye and Wright (1979) had suggested that there might be facilitators, but a thorough search of the literature revealed no research on this topic and no theoretical development. Therefore the author proposed to research facilitating factors and, if indicated, propose a facilitating factor theory.

1.6 Studies Concerning Pre-active Decision-making

A thorough search of the literature found only one study on nursing in which influences on instructional planning were a major focus. Hoshiko (1988) surveyed 284 nursing faculty in the U.S.A. about influences on content decisions. The subjects were randomly selected and the survey had a good (66.6%) response rate. She found six factors that were considered important influences on content by the subjects: 'social significance', 'aims of the institution', 'learners', 'logistics', 'faculty', and 'relevant social groups. That study was a questionnaire survey only and

thus the data are broad but not deep. As that study was published late in the course of this study, it had no influence on the design of this study; however the results will be compared later to the results of this study.

A thorough review of the general education literature on influences on instructional planning decisions may be found in Roberts (1989).

1.7 The Research Questions

The questions that this study attempted to answer were:

1. What frames influence nurse-academics' instructional planning decisions?

2. What facilitators influence nurse-academics' instructional planning decisions?

3 What frame factors make up the frames?

4. What facilitating factors make up the facilitators?

5. What is the relative size, strength and importance of the frames?

6. What is the relative size, strength and importance of the facilitators?

7. What is the effect of the frames and facilitators on the nurse-academics' decision-making space?

8. What are the important issues concerning instructional planning decisions that have arisen as a result of the transfer of nursing education to the tertiary education sector?

1.8 Pilot Study

In the year before the main study data were collected, a pilot study was done in order to practise techniques,and to trial questionnaires. Three tertiary institutions were included in the pilot study that were conveniently located, co-operative, and not targeted for the main study. One of the institutions was chosen because it was under the leadership of one of the members of the thesis committee and therefore could not have been used in the main study, for ethical reasons.

In the first semester, two institutions were visited for practice in methodological techniques such as interviewing and data recording. In the second semester, data were processed and analyzed and the third institution was visited to obtain further information. Questionnaires were developed and trialled. Reports were given to participating institutions.

CHAPTER II

METHODOLOGY

2.1 Design of the Study

In this study, elements of both quantitative and qualitative research methodologies were combined. Although there has been lengthy debate concerning the two paradigms in the literature, there has in recent times been a more harmonious relationship between proponents of the two conflicting views (Rist, 1977:47). Nolan and Short (1985:16) suggest 'the use of qualitative and quantitative modes of inquiry in tandem can lead to a more complete and comprehensive understanding of educational programs'. Mathison (1988:13) stated that 'it is necessary to use multiple methods and sources of data in the execution of a study in order to withstand critique by colleagues'. The main methods used in this study were interviewing and a questionnaire survey. The interview data were subjected to content analysis. According to Holsti (1969:28), all content data must be compared with some other data in order to state meaningful conclusions. In this study, the interview and questionnaire data were compared. Thus, multiple methods of data collection were used in order to increase the validity of the study by allowing the comparison of different types of data.

2.2 The Questionnaire Survey

2.2.1 The Participating Institutions

At the time of the study, 15 tertiary institutions in N.S.W. were running basic nursing courses. Fourteen were in colleges of advanced education and one in a university. The one university at the time of the data collection was excluded from the sample in order to promote homogeneity and because it had already been used in the pilot study. Two other colleges were excluded from the sample as they had also been used in the pilot study. Thus the sample was selected from twelve colleges. Since the sample selected did not include any universities, the institutions are referred to as colleges.

2.2.2 Selection of The Questionnaire Sample

The subjects for the questionnaire phases of the study were registered nurses who were lecturers in the basic nursing course in tertiary education institutions in New South Wales in 1987. In order to select subjects for questionnaire administration, each institution (n=12) was approached for a list of nurse-academics who had been employed there for at least a year. All institutions provided such a list. The subjects selected for questionnaire data collection were those with one year's employment in the institution. The criterion of one year's teaching experience in the college in which the lecturer was currently working was set in order to ensure that the subjects would be familiar with the institution. All nurse-academics who met that criterion were included regardless of the length of their teaching experience.

2.2.3 Development of the Instrument

During the pilot study, the researcher developed a questionnaire investigating Institutional Influences on instructional planning decisions. The questionnaire used a Likert Scale format with subjects asked to rate the items as to whether the latter were constraints or factors facilitating their instructional planning decisions. Each scale contained items derived from two sources. First, the empirical literature from the general field of education was represented by such items as 'Philosophy of the institution' and 'Textbooks'. Secondly, the researcher examined the pilot study data in detail for stated influences which were converted into items. The items were grouped into conceptually related clusters which will henceforth be referred to as The Roberts Scales.

In order to establish face validity, the questionnaire was vetted by four prominent nurse educators who were Heads of nursing departments not in the colleges visited in the main study. The questionnaire was sent for trialling to 42 nurse lecturers in the three institutions involved in the pilot study. The trial questionnaire return rate exceeded 50 per cent (n=22). The trial questionnaire data were processed on the Macquarie University VAX computer, using the SPSSX package (SPSSX Inc., 1986).

The trial data scales were refined by eliminating any item with a corrected item-total correlation of less than +/- 0.3. The refined scales were tested for internal consistency using the SPSSX procedure 'RELIABILITY' to generate the Cronbach's alpha coefficient. A criterion of 0.70 on the Alpha coefficient was set for inclusion of scales in the questionnaire. When the items were finalized, they were randomized for the questionnaire by shaking dice with the appropriate large numbers on them. Randomization was judged necessary to prevent subjects developing a mental set to a group of conceptually related items. The questionnaire was scored on a 5 point Likert scale format, with a score of 1 meaning 'strongly constrains'; 2, 'constrains'; 3, 'neither constrains nor facilitates'; 4, 'facilitates'; and 5, 'strongly facilitates'.

2.2.4 Administration of the Questionnaires

In 12 colleges across N.S.W., 86 questionnaires were administered to selected nurse-academics. To control for historical factors, the questionnaires were administered to the mail sample at the same time as interviews related to that questionnaire were being conducted in the colleges visited. The questionnaire was accompanied by a personalized letter explaining the purpose of the study and requesting help, a stamped, self-addressed envelope and a stamped self-addressed postcard. The postcard contained the subject's name and a message that the subject had posted the questionnaire. It was to be posted at the time of posting the questionnaire to notify the researcher that the subject had returned the questionnaire. This made it possible to preserve the respondents' anonymity and eliminate respondents from the follow-up list, thus

sparing the time and expense of a full round of follow-up questionnaires. Subjects not responding to the first questionnaire were sent a follow-up questionnaire with another personalized letter, questionnaire and stamped, self-addressed envelope. A minor alteration in the format of the title page of the follow-up questionnaire enabled the researcher to distinguish first-time respondents from the follow-up group so that the two groups could be tested for significant differences on scores on The Roberts Scales.

2.2.5 Data Processing and Analysis

The data from the questionnaires were typed into the Macquarie University VAX computer, and processed by means of the SPSSX package (SPSS Inc.:1986). The data from the questionnaires were in effect self-coded by the respondents, so required no further coding.

An analysis of internal consistency was carried out on the questionnaire data from the main study. Items that had a corrected item-total correlation of less than +/- 0.3 were omitted from the scales. Re-combination of the scales was carried out in order to construct scales with sufficient items to be useful for further analysis. A level of confidence of 95% ($p \leq 0.05$) was set for the questionnaire data.

The questionnaire data were compiled into histograms using a graph-generating procedure on the Apple Macintosh Plus computer. To show the data on a histogram, it was necessary to group the scores into equal intervals (Burroughs, 1971:155). As the responses were in five categories (1,2,3,4 and 5), representing 40 decimal intervals, the scores were divided into categories that represented five equal intervals of 0.8. The data were accordingly recoded so that a mean score of 1.0 to less than 1.8 was classified as 'strongly constrains'; 1.8 to less than 2.6 was 'constrains'; 2.6 to less than 3.4 was 'neutral'; 3.4 to less than 4.2 was 'facilitates'; and 4.2 to 5.0 was 'strongly facilitates'. This recoding counteracted the tendency for subjects to choose the middle scores and was applied to all histograms and tables in the results section. Data analysis showed that very few subjects' scores were in the extreme zones; therefore these categories were subsequently combined with 'constrains' and 'facilitates' to produce a 'constrains' zone from 1.0 to less than 2.6 and a 'facilitates' zone from 3.4 to 5.0, with the neutral zone unchanged.

Descriptive data were generated using the procedures 'CONDESCRIPTIVE', 'FREQUENCIES' and 'BREAKDOWN'.

2.3 The Interviews

2.3.1 The Settings

Four colleges were selected to participate in the interview phase of the study. In order to obtain a representative sample of tertiary institutions, two colleges from the Sydney metropolitan area, one regional metropolitan and one non-metropolitan college were selected for the interview phase of the study. Two colleges were selected from the Sydney metropolitan group as it had approximately twice as many students as the non-Sydney metropolitan group. The Sydney metropolitan colleges comprised one large (>300 students) and one small (<300 students) college in order to represent both sizes of college. The regional metropolitan college was large and the non-metropolitan college was small. Thus the sample had two large and two small colleges in it.

2.3.2 Selection of the Interview Sample

The subjects for the interview phase of the study were registered nurses who were lecturers in the basic nursing course in tertiary education institutions in New South Wales in 1987. In order to select subjects for interviews, lists of staff were obtained and possible interview subjects identified who met the criteria for the study explained below. In one college, the Head selected the participants who were requested to volunteer. In two other colleges, the Head called a meeting for the researcher to request volunteers. Some subjects were obtained in this way, with the remainder being approached directly by the researcher. In the fourth college, the researcher selected possible subjects from a list. She decided that of those who met the criteria, those who were in their office on the first visit would be approached to participate in the study until the required sample was obtained. All lecturers approached agreed to participate. The choosing of three subjects by the Head raised the issue of the subjects' freedom of choice to participate and thus generating a possible bias in the data. However, the candid nature of their responses indicated that they were hardly afraid of the Head. The researcher explained to each subject the purposes and usefulness of the research and the subject's expected commitment. The context of the research and the researcher's independence of the system were also explained. The researcher and the subjects negotiated the times for data collection. The Heads were not involved in dealings between the researcher and subjects beyond the point of subject selection.

The interview sample comprised nurse-academics at the lecturer level in the four colleges. Three of the four colleges had nursing departments divided into sections such as Nursing Studies, Nursing Science, Behavioural Science, Life Science, Health, and Professional Nursing Studies. The interview subjects were limited to the Nursing Studies and Health sections to promote homogeneity. The lecturers from the Nursing Science or Science sections that existed in two of the colleges were excluded, as were those from the Professional Nursing Studies section, who mainly taught post-basic courses. Lecturers in Nursing Science might have had different perceptions from those in Nursing Studies as people who teach in a Science section may value science more than those who teach in a Nursing Studies section. Restricting the sample also limited the subjects to a manageable number. To have included the Nursing Science sections would have meant interviewing more lecturers or splitting the sample. The former was beyond the resources of the study, while the latter would have resulted in undesirably small numbers for each group. Therefore the subjects were restricted to Nursing Studies and Health. A sample of a quarter of the population for the larger and medium sized colleges and one-third for the smaller colleges was decided upon. Thus, a total sample of 14 was selected, comprising 3 from each of the small colleges and 4 from each of the larger colleges.

In each college, one male lecturer was included in the interview sample, which meant that males comprised a quarter of the sample in the larger colleges, one-third of the sample in the smaller colleges and 28% of the whole sample. It was considered preferable to have the males from the smaller colleges included, even if they were slightly over-represented, so that the male point of view could be included for every college visited. Therefore, the sample comprised ten female and four male nurse-academics. Lecturers interviewed are referred to as (s)he throughout this document in order to camouflage their gender.

Subjects taught a variety of nursing and science subjects; no attempt was made to standardize for subject matter taught.

The subjects selected for interview had at least five years' teaching experience. They had been involved in teaching nursing in hospital schools of nursing for at least one year. They had also taught in the college in which they were presently employed for at least a year. The criterion of one year's teaching experience in the college in which the lecturer was currently working was set in order to ensure that the subjects would be familiar with the institution.

2.3.3 Collection of Data

The researcher interviewed the 14 interview subjects about what influences they perceived were operating on their instructional planning decisions for the unit they were giving during the first semester of 1987. In order to capture current data, lecturers were interviewed about their current planning. As the nursing system was still in a state of settling in to the tertiary system, all lecturers were involved in planning instruction. Because the researcher was using frame factor theory as a theoretical framework, and because of the limited time available with each subject, the interviews in the first phase of data collection (1987) concentrated on frame factors and did not explore facilitating factors.

Before the interview, each subject was asked to complete a questionnaire. An interview schedule was then developed, using the items that the subject had identified as most constraining. The subject was then given a semi-structured interview about his/her perceptions of the constraints of the frames as they affected instructional planning decisions. To avoid confining the interview to what was on the questionnaire, the subjects were asked if there were any other influences. With the permission of the subjects, audiotapes of the interviews were made using a portable tape recorder with a sensitive microphone.

After the first analysis of the interview data, it was considered that, because of the exploratory nature of the study, the data collected ranged over a great number of areas, but lacked some depth. It was decided that more in-depth data concerning the most important influences would add to the emerging picture of influences on nurse-academics' instructional planning decisions. The questionnaire data provided information on both frame and facilitating factors, while the interview data mainly provided information on frame factors. The later (1988) data comprised nurse-academics' perceptions of the effects of the most important influences, both constraining and facilitating, on their instructional planning decisions. Therefore, the 11 subjects who were still working in the N.S.W. college system were approached for their permission to give another interview. All subjects agreed, and all were interviewed again in the second semester of 1988. Subjects were not asked to recall influences at the time of previous data collection, as the data could have been less valid owing to diminished recall over elapsed time. Instead, they were asked to comment concerning influences at the time of the follow-up data collection.

The nature of the methods used in this study meant that for some topics, only questionnaire or interview data were elicited. In some cases there were interview data only, because the interview ranged beyond the topics on the questionnaire. In other cases, there were questionnaire data only because the interview covered a more restricted range of topics than the questionnaire.

2.3.4 Data Processing and Analysis

The audiotapes of the interviews were transcribed by the researcher into the Apple Macintosh computer, using the 'Write Now' word processor and a dictaphone. All possible precautions were taken to ensure an accurate transcription.

From the word processor file, the researcher next generated hard copy, in terms of a 'reconstructed interview' (Smith, 1984:157) that omitted such items as superfluous conversation or references, lengthy anecdotes, repetition, and questions from the researcher that interrupted the flow of the dialogue. The data from the second round of interviews were processed in the same manner as the previous interviews.

Following the transcription, summaries were sent to all subjects with a form to indicate if the summary was accurate and to give an opportunity for the subjects to change their statements. Only a few minor changes were noted. Smith (1984:76) also found only a few minor changes

were requested. It is possible that after several months the subjects' memory of the interviews may have dimmed slightly, but they would probably have sought to change anything that conflicted with their views. In view of the lack of change in the first set of interview summaries, no summaries were sent for the data from the second round of interviews.

The content of the transcripts was then analysed, using thematic categories. The transcript was broken into units which roughly corresponded to the interviewee's thought on a subject. Units were identified and then sorted on the hard copy using highlighters of different colours. Subject matter categories were used that corresponded to the influences derived earlier, for example 'College'. The categories reflected the purpose of the research, were exhaustive, independent and mutually exclusive (Holsti, 1969:95). Units were coded according to college, lecturer, and page number so that they could be traced back to the original transcript and thence the audiotape. Sorted units were then recombined into major categories that corresponded to major influences. Further sorting then produced themes. When the data were completely sorted, the researcher analysed the data and noted the trends and the number of subjects who reported particular influences on their instructional planning decisions.

2.4 Classroom Observation

In order to ascertain the degree to which lecturers carried out their plans, and thus increase the validity of the data, the researcher observed the lecturers teaching. The researcher observed one lecture, tutorial and nursing laboratory per subject, except where the lecturer did not teach that type of session. A total of 54 hours of classroom instruction were observed. The researcher interviewed the subjects before the lessons to elicit the lesson plan. Copies of written plans were obtained. During the lesson, the researcher sat at the back of the room, observed the proceedings and made written notes on what parts of the lesson plan were implemented, what parts were modifications of the plan and happenings that were completely unplanned. It would have been beyond the resources of the study to audio-tape or video-tape the lessons. It was judged that written observation notes were sufficient to stimulate the lecturer's recall of the lesson, and were less obtrusive and therefore less likely to alter the course of the lesson. The subjects were aware that they were being observed. Within the framework of the present research, it was not possible either to eliminate the Hawthorne effect or to estimate its strength.

The researcher interviewed the subjects as soon as possible after the session to confirm the observed deviations from the lesson plan and ascertain the reasons for them. The opportunity was also there to establish if deviations were true deviations and not part of a mental plan. The researcher used a form of stimulated recall in which she asked questions from the lesson observation notes rather than audio-tape or video-tape.

The classroom observation data demonstrated that nurse-academics do implement their plans. In general, lecturers held to their planned objectives, content, sequence and strategies. The only area in which the lecturers made minor changes was to the pacing of the lecture.

CHAPTER 111

RESULTS

3.1 The Response Rate

The overall response rate was 77% and therefore sufficient to suggest external validity. The results for the questionnaire data and the interview data were consistent. That is, the interviewees' scores on the Roberts Scales were not significantly different from those of the rest of the questionnaire sample.

3.2 The Sample

The interview sample comprised 14 nurse-academics at the lecturer level in the four colleges: four from each of the large colleges and three from each of the small colleges.

The questionnaire survey sample comprised 66 nurse-academics from 12 colleges, of whom 28% were males and 72% were females, 80% were from nursing departments and 20% from science departments of the nursing schools, 57% were from large colleges and 43% from small colleges, and 90% were initial responders and 10% were follow-ups. The results for sex, department, time of response, and whether or not the subjects were interviewees or not, were not significant as determined by *t*-tests ($p \leq 0.05$).

There were some differences in groups of study and non-study colleges. The scores of respondents in colleges visited by the researcher were statistically significantly different on six clusters from those of respondents from colleges not visited by the researcher. Respondents from colleges visited indicated that they perceived themselves as slightly more constrained by the institution than those in institutions not visited. However, all of the mean scores on the scales of both groups were in the 'neutral' zone (2.7 to 3.4). Accordingly, the data for all subjects are reported together in the results section rather than separated according to the above groupings.

3.3 Presentation of the Results

A 'frame' or 'frame factor' is defined as one in which more questionnaire or interview subjects were constrained than were not influenced or were facilitated. A facilitating factor is one in which more questionnaire or interview subjects were facilitated than were constrained or not influenced. a factor which did not influence was one in which more were not influenced than were framed or facilitated. A 'frame', 'frame factor', 'facilitator' or 'facilitating factor' in this analysis is one rated as constraining or facilitating by 49% or more of questionnaire respondents, or six lecturers. By chance alone, 33.3% of subjects could have rated any item a constraint or facilitator. More than 48% or six lecturers shows a frame or facilitating factor. This percentage was determined by a 'goodness of fit' statistic. A strong frame or facilitating factor in this work is defined as one rated as constraining by over two-thirds (68% or more) of questionnaire respondents. From 35% to 48% of questionnaire respondents, or three to six lecturers rating a topic as a frame or facilitating factor shows a tendency to be a frame or facilitating factor. If an item was rated as not influential by 48% or more of respondents, or it was rated by fewer than 35% as constraining and 35% as facilitating, it was classified as a non-influential factor. Items that were on the questionnaire but not included in a Roberts Scale are reported as 'singleton' items.

The subjects who returned the questionnaire are referred to in the text as 'respondents'. The lecturers interviewed are referred to as 'lecturers'. To illuminate the results, relevant quotations are presented that are typical of the opinions of the lecturers. In the interests of conciseness, only important results are discussed. To preserve their anonymity, the 14 lecturers interviewed are referred to in this report by a randomly selected code number. The parentheses after each quotation contain the lecturer's number, tape recording number and page number of the transcript, for example (1/05/10) would indicate the unit came from lecturer 1, tape number 5 and the tenth page of the transcript.

In this study, College A was a small Sydney Metropolitan college, College B was a small country college, College C was a large Sydney metropolitan college and College D was a large non-Sydney metropolitan college.

3.4 Influence of the College

The college influences comprise the influences of the institution outside the nursing department.

The influence of the college frames was investigated on the questionnaire by the clusters 'Governance and Bureaucracy', 'History, Values and Characteristics', and 'Policies and Regulations'. Figure 1 and Tables 1-3 show the results for these clusters.

3.4.1. Academic Governance

Of the four colleges studied, no two had the same management structure, or division of responsibility. As would be expected, the larger colleges had more complex structures. It was the common features of the administrative structure (they all had Heads, boards, committees, and similar histories) that had the most significance, and even these features were not perceived as influential.

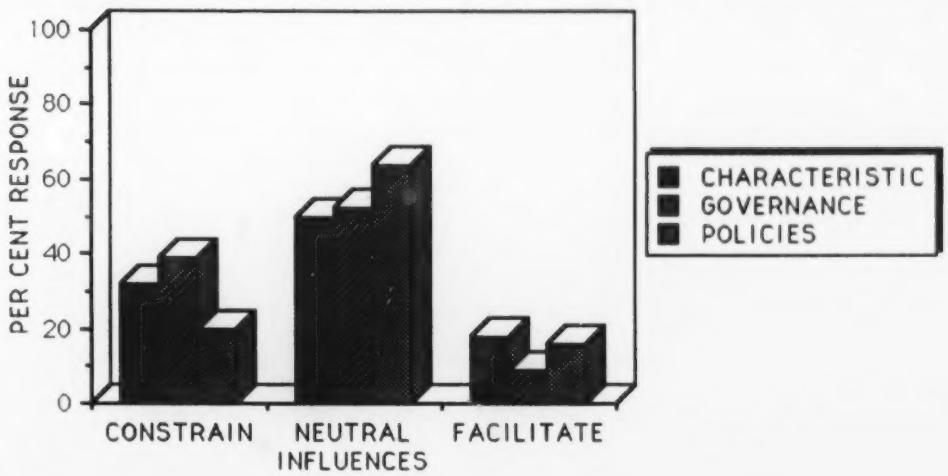

FIGURE 1

Effects of College Influences on Instructional Planning Decisions

TABLE 1
The 'Governance and Bureaucracy' Cluster

(Cronbach a = 0.85)

	Con %	Neut %	Fac %
Whole Scale	39	52	09
Factors Tending to Constrain (35-48%)			
Management style of college hierarchy	42	37	21
Non-influential Factors (<35% constrained and <35% facilitated or >48% neutral)			
Council of the college	15	73	12
College administration	19	66	15
Degree of centralization of the administration	21	66	13
Education committee of the College	19	63	18
Decisions made outside the nursing department	34	60	06
Committees above nursing department level	34	59	07
Power of the Principal	25	59	16
Control of college committees	26	59	15
Board of Studies/ Faculty Board	23	59	18
Organization of the academic year	34	41	25

Key: (for this and subsequent tables) Con = Constrains
Neut = Neither constrains nor facilitates (neutral) Fac = Facilitates

The governance and bureaucracy of the college was perceived as not being influential by the majority (52%), although they were perceived as a constraint by some (39%) questionnaire respondents and facilitating by a few (19%) (see Figure 1). It therefore had a tendency to be a frame. 'Management style of college hierarchy' was perceived by some of the respondents (42%) as constraining.

Table 1 shows the full results for the 'Governance and Bureaucracy' cluster. As Table 1 shows, most of the questionnaire items concerning the governance and bureaucracy of the college were perceived as not influencing instructional planning decisions. Thus the components of the hierarchy outside the nursing department in the college were not perceived as influential. 'Management style of college hierarchy' (42%), tended to be constraining'.

A breakdown of the cluster 'Governance and Bureaucracy' by college showed that the respondents from the two smaller colleges were not influenced by the governance and bureaucracy, while those from the two larger ones were.

The singleton item 'Allocation of funding by the college' was perceived as a constraint on instructional planning decisions by a majority (51%) of the questionnaire respondents, and therefore was a frame factor. Another singleton item, 'Control of funding of nursing course', however, was seen as not influential by a majority of respondents (51%). This finding indicates that control of funding was not an issue, but the allocation of funds by the college was important. Most of the important frame factors found in this study were related in some way to the funding of the nursing course. Therefore, funding is a very important theme that runs through the results of this study, flowing through the allocation of funding by the college and the nursing department.

Funding was inextricably linked with the number of students enrolled, which in turn determined the number of staff who could be employed. At the beginning of the nursing courses, enrolments were insufficient in some colleges. This resulted in some cases in a lowering of the required Higher School Certificate (H.S.C.) aggregate for entry into the course, and increasing pressure from the hierarchy to retain students. These forces resulted in a perceived lowering of standards for content and for assessment, for example:

> *The students are worth X thousand dollars each and there's pressure [to build up the student numbers]. ... It becomes apparent that some of the content needs to be looked at in the level it's pitched at. I get exam papers with the question not answered and notes that say things like 'Please, I not understand the question, please help me.' (8/37/07)*

In some colleges, students had been deliberately retained in the course in order to build up the numbers and therefore the funding. Many of these students needed remedial work with respect to language, which added to the workload.

The funding also affected staffing ratios, which in turn affected the workload and thus strategies chosen by the lecturers. The staffing ratios particularly affected were those for the clinical component which for safety reasons demands a low staff-student ratio and also the employment of part-time staff for clinical teaching.

Funding also affected the structure of the course, for example the total length of the course and the diminution of the clinical component and therefore affected instructional planning decisions.

In the follow-up interviews, the 11 lecturers were asked if they felt any constraints of funding on instructional planning decisions. Nine stated that they felt that there was inadequate funding for staff, particularly in relation to the quantity and quality of staffing for clinical practice, for example:

It's a very sad thing that in this institution we kept having to cut our clinical because we don't have enough staff. (6/91/06)

The lack of funding for staff obviously increases the workload.

The lack of funding was also perceived by four lecturers to affect the facilities and equipment available for use. The lack of funding for equipment and staff in turn affected the strategies that the lecturers used to deliver the curriculum:

I don't think there is enough audio-visual such as videos and things like that. You become more teacher dependent. (9/93/08)

The lack of funds, therefore affected nurse-academics' instructional planning decisions in terms of strategies used and the increased workload.

The Governance and Bureaucracy frame influenced only a minority of nurse-academics in this questionnaire sample. Management style of the college hierarchy had a tendency to frame. However, the interview data suggest that, in the colleges visited, at least, funding was an important frame factor.

3.4.2 Characteristics, History and Values

The characteristics, history, and values of the institution were not perceived by questionnaire respondents as an influence on nurse-academics' instructional planning decisions, as half (50%) of the respondents perceived themselves neither constrained nor facilitated, while about one-third (32%) perceived themselves constrained and about one-fifth (18%) perceived themselves facilitated (See Figure 1). A breakdown of the cluster showed that, of the colleges visited by the researcher, only the respondents from College C, a large, traditional college, perceived themselves constrained by these factors. Scores on the cluster 'Characteristics, History and Values' of the institution were fairly strongly correlated with scores on the cluster 'Governance and Bureaucracy' ($r = 0.7$; $p = \leq 0.001$) and 'Policies and Regulations' ($r = 0.6$; $p \leq 0.001$). Table 2 shows the results for the 'Characteristics, History and Values' cluster.

TABLE 2
The 'Characteristics/History/Values' Cluster
(Cronbach a = 0.76)

	Con %	Neut %	Fac %
Whole Scale	32	50	18
Factors Tending to Constrain (35-48%)			
Status of nursing within the college	38	47	15
Non-influential Factors (<35% constrained and <35% facilitated or >48% neutral)			
Prestige of the college	12	56	32
Traditions of the college	29	49	22
Size of college	32	44	24
College's values, e.g. emphasis on science	29	43	28
Location of library	34	41	25
Facilitating Factors (49-66%)			
Philosophy of the college	15	34	51

Colleges A and B were comparatively small and self-contained, with some travel for teaching necessary for lecturers in College A. The layout of these colleges presented no constraints on instructional planning decisions. Colleges C and D were both large, and both presented problems in terms of inconvenience and time wasted in travelling.

A breakdown of the item 'Location of the library' by college showed that the respondents from College C perceived the location of the library as a significant constraint on instructional planning decisions. All lecturers interviewed in College C stated that the distance of the college library, which was a 15 minute walk from their offices, was a problem for them, for example:

> *You spend 10 or 20 minutes walking there and then walking back, ... and you can't do it in between lectures because it's too far. And if you say all right, why don't you take your overhead transparencies and prepare some of your lectures over there, that's quite a heavy load to carry, because you have to carry books. And also, if you want to drive over, you need to have a special pass. (3/38/02)*

However, the distance of the library led some lecturers to devise alternative strategies for acquisition of resource information, such as developing a personal collection of relevant resource material. The major problem with the approach of each person becoming self-sufficient in terms of teaching resources and under-using the library is that the common resource pool may not be sufficiently built up and the library users may suffer.

In College D, the major constraint of the geography of the college was the utilization of the tutorial rooms and nursing laboratory facilities in the large hospital annexe many kilometres away at the other end of the city. Two lecturers found that the facilities there were constraining, for example:

> *If I want to do problem solving there I have to take all the books with me, or make sure that the week before I tell the students, when you come in next week, bring your textbooks with you. (12/44/03)*

So, for College D, the isolation of the distant hospital annexe was the strongest constraint in the geography of the college.

Thus, the geographical features of the college, in particular the location of the library and the teaching areas, were a frame factor in the larger colleges.

The questionnaire data suggest that the 'History of the college' (69%), 'Prestige of the college' (51%), and 'Traditions of the college' (49%) were not influential. Size of college and College values were also not perceived as influential by questionnaire respondents. However, the 'Status of nursing within the college', which relates to the history of the college, had a tendency to constrain (38%). The status of nursing in the college was an issue that indirectly affected nurse-academics' instructional planning decisions through the atmosphere it created. The status of nursing, as a predominantly female quasi-profession and a relative newcomer to tertiary education, was comparatively low. The status of nursing in the tertiary sector may be related to nursing's low status compared with other health professions. The low status of nursing can be seen by comparing both the total length of the nursing course and the tertiary award with that of other health professional courses. The status of nursing was also related to government funding for the nursing course, as the higher status courses were longer and therefore possibly more expensive. The nursing course was also a low status course compared with teacher education which was at the degree level and which took three to four years.

The lack of status affected the nurse-academics in terms of emotional reaction and power in the political structure and on policy-making committees, for example:

> *We're very constrained here by the fact that this was a teacher education college.*

> *(14/64/07) There is a rigid bureaucracy here that is totally aligned to teacher ed. Nursing is the newcomer ... They tolerate us. (14/84/02) We haven't got the power in this college that teachers have, and that's patently obvious. (14/31/10)*

There was bitterness amongst the nurse-academics who felt that nursing brought a great deal of money to the colleges and yet 'We're treated as poor relatives and patronized.' (7/45/07).

The status of nursing affected instructional planning decisions, for example, by the nurse-academics' higher expectations of the students 'to prove that they're not of lower standing and a lower educative level' (4/60/03). It also affected the nurse-academics by stimulating them to show that they had superior skills in the area of lesson planning and curriculum development: skills which had been learned in their Diploma of Nursing Education courses.

Thus, the history of the college had little apparent effect on nurse-academics' instructional planning decisions except indirectly through the status of nursing. The latter appeared to affect instructional planning decisions indirectly through an emotional reaction.

The 'Philosophy of the college' was a facilitating factor for the majority (51%). One of the colleges visited was a religious institution whose philosophy had been stated in the curriculum. None of the other colleges had a philosophy as such stated in their handbooks, or published. The philosophy of the college, to the extent that it existed, would have been transmitted through the Head of the nursing department and the curriculum submission.

The influence of the values of the college education system on nurse-academics was mainly through the effect these had on the workload. Most of the nurse-academics had previously worked in the hospital system. During that time, most of them spent years acquiring such qualifications as post-basic clinical certificates, for example midwifery, or college diplomas of nursing education (D.N.E.) which were run by the hospitals and were the appropriate credentials for promotion in the hospital sector.

Nurse educators were transferred suddenly into the tertiary system in which academic qualifications at the degree level were an essential rather than a peripheral asset. They were then in a position of having to acquire the correct credentials to work in the tertiary education sector, for example:

> *If you weren't fortunate enough or cluey enough to go and do a degree years ago, you're behind the eight ball. I've done nothing else but do courses since I left school. I've done mental retardation, general nursing, intensive care, then the Dip Teach, then I started my degree. (10/25/08)*

Thus, many nurse-academics found themselves in a situation where their credentials were not congruent with the credentials for the tertiary education system. They were faced with not only adapting to a system that was new to them, but also with an increased workload through the need to acquire a degree to become academically respectable. Furthermore, those who had been far-sighted enough to acquire a degree before the transfer to the college system were not able to acquire degrees in nursing in Australia. Thus, most of them had degrees in education or administration, which did not build up their professional nursing knowledge. This was in contrast to their colleagues in Life Science, for example, who had degrees in the cognate area in which they were teaching.

In the tertiary sector, such behaviours as acquiring basic and post-graduate degrees, conducting research, publishing papers and going to conferences are expected. The effect of the press for academic behaviours and qualifications was an indirect one, through the workload it created for people who were not only carrying a full teaching load which may have been higher than that of other academics but were also working to develop the existing course and prepare new

courses. The area of academic behaviour is therefore related to the workload.

Ten of the original 14 lecturers were working on a tertiary degree. The pressure to get a degree was a strong frame factor, acting through the time factor. Time spent on getting a degree was time not spent on planning instruction. Eight lecturers felt pressured, through their own expectations, peer pressure, pressure from the system for example at job interview, or more directly from the Head of the nursing department, to undertake degrees or to complete them, for example:

> *There's definitely a push to do higher degrees if you're wanting to move anywhere in your career. (6/19/10)*

Thus, pressure to get a degree was a strong, if indirect, frame factor which had its main effect through the workload.

There was an emerging pressure for the nurse-academics to do research. Six lecturers stated that staff were encouraged to do research, that there was an expectation that staff would do research, or that research was taken into consideration in criteria for promotion, for example:

> *There's certainly a push to do research. Unfortunately, it was rather nastily brought up at a meeting that there is all this money there and nobody's doing research. [The nurse-academics] got all defensive, angry and said we don't have time. (6/19/10)*

The emphasis on research was observed by the researcher to be stronger at the large metropolitan college in the study. In Colleges A and C, some people had been given grants to do research. Research opportunities were published in the staff bulletin.

Five lecturers stated that they were not able to get what they considered to be adequate time to do the professional reading or video-viewing that would keep them up to date in their content areas. The nurse-academics were under enormous pressure, and resentful that so much was expected of them; they had quickly to become well qualified academics to raise the level of nursing prestige within the tertiary sector, yet at the same time, the work of setting up a new course had militated against professional development:

> *The sorts of things that academics do, keep up to date professionally, go and read the journals, work on research projects; we're just being torn every which way thinking that we should do this and do our master's degree and so on. There are certain areas that suffer .... there's not enough time spent on preparing lessons. ... It constrains maybe in the time available to really consider carefully what you are putting into how the curriculum is implemented. (6/50/08)*

Thus, this lecturer felt that the lack of time from the workload and the pressure to be an academic resulted in not enough time spent on preparing lessons and making sure that the curriculum was implemented carefully. In the follow-up interviews, the nurse-academics denied that the pressure to become an academic affected their planning directly. It affected them indirectly through time that being an academic consumed:

> *It does [affect] things in terms of status and a personal sense of power and worth, maybe. I personally feel that I'm a frustrated academic in this place. I've got to write a paper for next month for presentation at an international congress and I can never get to it. (8/92/17)*

A cross-correlation showed that the questionnaire respondents' scores on the cluster 'Characteristics, History and Values' of the institution were fairly strongly correlated with their scores

on the cluster 'Time' ($r = 0.7$; $p \leq .001$), which related to their perceptions of the effects of the workload.

Some lecturers mentioned that pressure to become an academic had positive effects such as teaching more theory and raising professional and scholarly standards among the students.

Four lecturers had minimal contact with colleagues in other colleges through such things as friendships, networks and residential schools. The sharing of ideas was mainly informal, and an indirect influence. One lecturer was conscious of the results of a lack of colleagueship:

> *The constraints of not having time to actually develop collegial relationships ... the payoffs for our students are obvious and they're absolutely immense. (8/23/10)*

The pressure to acquire a degree and therefore increase eligibility for promotion and standards of nursing academia was a strong constraint with the other academic behaviours being more nebulous influences. They were not perceived as a direct influence on instructional planning decisions, nor on the type of nurse that was being produced.

3.4.3 Policies and Regulations

Policies and regulations were perceived as a weak influence on nurse-academics' instructional planning decisions, as a majority (52%) rated the cluster 'Policies and Regulations' as not influential, while one-fifth were constrained and 16% facilitated (see Figure 2). A breakdown of the results for this cluster by college showed that subjects from all of the colleges visited by the researcher scored in the neutral zone on this cluster. Table 3 shows the full results for the items in the cluster 'Policies and Regulations'.

TABLE 3
The 'College Policies/Regulations' Cluster

(Cronbach a = 0.82)

	Con %	Neut %	Fac %
Whole Scale	20	64	16
Non-influential Factors (<35% constrained and <35% facilitated or >48% neutral)			
Deadline for enrolments	19	66	15
Regulations on pre-requisites	13	63	24
Policies on student progression	21	60	19
Regulations on co-requisites	13	60	27
Policy on year-long or semester progression	21	56	24
Policies on attendance	21	47	32
Factors Tending to Facilitate (35-48%)			
Policy re: clinical experience	29	34	37

All of the colleges visited by the researcher had policies on admission, progression, attendance and assessment. These policies were published either in the college handbook or nursing department handbooks and were public knowledge.

The majority (59%) of questionnaire respondents found 'Policies on staffing clinical practice' (a singleton item) constraining; therefore it was a frame factor. This finding was related to the ratio of students to supervisors and will be discussed under 'Workload'. The policy on staffing clinical

practice was also related to the funding as disbursed by the college. The funding for clinical practice was a very important issue as the clinical component of the course was the most expensive by virtue of the low staff-student ratios required (1:6 to 1:9) in comparison with tutorials and nursing laboratories (1:15 to 1:30) and lectures (1:100 to 1:120). An increase in the ratio for clinical teaching constrained instructional planning decisions in that the more students a lecturer must supervise in the clinical area, the more limited the choice of strategies. The staff-student ratios for the various types of teaching were also inter-related. The total funding for the course had to be divided among the various types of teaching as outlined above. Therefore, if the clinical teaching ratio was to remain low, it had to be compensated for in ever-increasing numbers of students in the other forms of teaching. Thus, the clinical teaching ratios tended to influence the number of students in nursing laboratories, tutorials and lectures. This size of the class was therefore influenced by the funding for and policy on staffing clinical practice.

Some respondents (37%) found 'Policy on clinical experience' facilitating; therefore it had a tendency to facilitate.

One policy that indirectly affected planning learning experiences for students was the college's policy on staff maintaining their own clinical expertise. Almost half of the respondents (44%) found 'Policies on staff doing their own clinical practice' (a singleton item) facilitating; therefore it was a facilitating factor. A breakdown of the item showed that it was perceived as facilitating by the lecturers in College B but as not affecting the other colleges visited. In College B, the Deputy Principal had just issued a policy that staff could do their own clinical practice, therefore the nurse-academics were aware of this policy and its implications. Other colleges had different policies, but basically lecturers were allowed to arrange clinical updates on an honorary basis or do outside work with permission and the college paid their salaries if it was in college hours. The most likely times for this were during mid-semester or end-of-semester breaks when teaching would not be disrupted, but which were usually occupied with clinical teaching. The lecturers agreed in principle that it was a good thing but the workload militated against it. Two lecturers worked one shift per week outside college hours, but working in college hours was difficult to arrange:

> *We can do it in college time, on a voluntary basis. You have to write to a Director of Nursing and plan to work in a particular area for a week. You've got to arrange it at a time when there's no students in. Sometimes it really is difficult. ... Some hospitals want you to be there for a week, because otherwise they can't keep track of everybody. (3/38/16)*

The lecturers were not discouraged from maintaining their clinical competence but they have had to combat attitudes from the bureaucracy that supervising students on clinical would suffice. Thus, policies for maintaining clinical competence affected the planning of learning experiences indirectly through keeping the lecturers up to date clinically, which in turn affected decisions about content.

The college policies and regulations generally allowed the nurse-academics a fairly large decision-making space. However, policies on staffing clinical practicum emerged as a frame factor. Policies on staff doing their own clinical practice and policies on clinical practice tended to be facilitating.

3.4.4 Other Departments

The other departments in the college were a weak influence on nurse-academics' instructional planning decisions. Table 4 shows the full results for the singleton items concerning other departments.

TABLE 4

The Influence of Other Departments

(Singleton Items)

	Con %	Neut %	Fac %
Factors Constraining (35-48%)			
Other departments' timetables	51	46	03
Non-influential Factors (<35% constrained and <35% facilitated or >48% neutral)			
Power of academics in other departments	19	72	08
Competition between faculties in college	29	66	05
Patterns of communication with other departments	22	59	19
Attitudes of non-nurse academics	32	56	12
Factors Tending to Facilitate (33-48%)			
Interaction with academics from other departments	18	37	46
Liaison with other departments	12	49	39

'Other departments' timetables' were perceived as a frame factor (51%). A breakdown of this item by college showed that all colleges visited by the researcher found other departments' timetables constraining. In all colleges, there was some sharing of facilities with other departments which meant that their timetables had to be taken into consideration during planning. Some respondents (39%) found 'Liaison with other departments' facilitating, particularly those in Colleges B and D. Some respondents (46%) found 'Interaction with academics from other departments' facilitating.

There was a distinct isolation of nursing from other departments where the nursing department was geographically distant and was self-contained. The geographical isolation militated against developing relationships with staff in other faculties. Relationships with the staff in other departments appeared to be reasonably cordial and co-operative at the level of individual interactions. However, other departments in general did not exert much influence on the instructional planning decisions of nurse-academics except for the constraint of their timetables. Therefore, the other departments allowed nurse-academics a great deal of decision-making space.

3. 5 Influence of the Nursing Department

The nursing department influenced instructional planning decisions. They consisted of the Head, bureaucracy, workload and time The results for these are shown in Figures 2 and 3 and Tables 5-9.

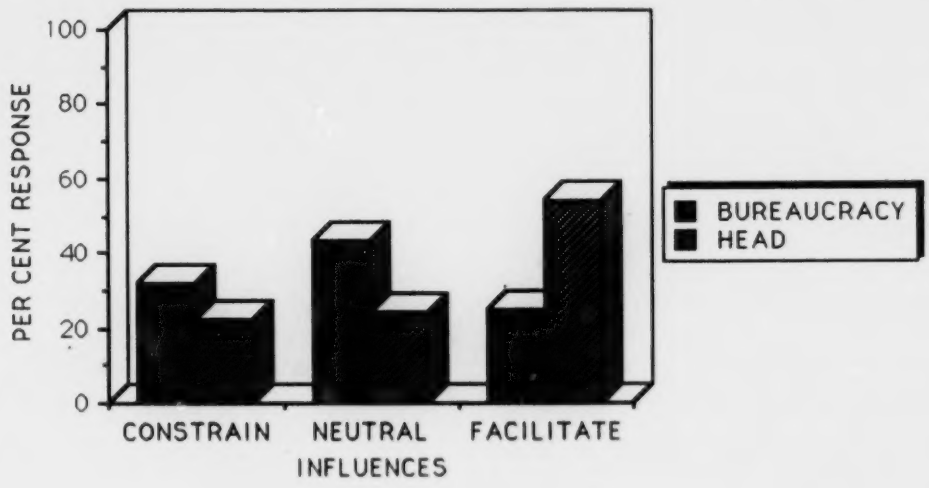

FIGURE 2
Effects of Head and Bureaucracy on Instructional Planning Decisions

TABLE 5
The 'Bureaucracy' Cluster

(Cronbach a = 0.86)

	Con %	Neut %	Fac %
Whole Scale	32	43	25
Factors Tending to Constrain (35-48%)			
Communication patterns within nursing department	43	23	34
Allocation of funds within nursing department	40	37	23
Organizational structure of staff	37	31	32
Non-influential Factors (<35% constrained and <35% facilitated or >48% neutral)			
Degree of bureaucracy in nursing department	34	50	16
Management style of lecturers	26	44	30
Decisions made by committees of nursing department	29	40	31
Management style of senior lecturers	32	38	30
Factors Tending to Facilitate (33-48%)			
Nursing department administration	31	27	41
Size of staff body	32	28	40

3.5.1 Organizational Structure

The bureaucratic structure of the nursing department was not perceived as a strong influence on nurse-academics' instructional planning decisions (43%) while it was perceived as a constraint by one-third (32%) and a facilitator by one-quarter (see Figure 2).
A breakdown of the cluster by college showed that the organizational structure was perceived as facilitating by respondents from College B, which had a simple structure, and constraining by respondents from College D which had the most complex structure. The bureaucratic structure of the school was perceived to be more constraining in the larger schools, as it tended to be more complex and could lead to a lack of communication. It affected instructional planning in terms of 'what I'm supposed to teach, and how much preparation I have to do, and how much time I have.' (5/34/13) It resulted in the nurse-academics spending a lot of energy on understanding how decisions were being made, and how best to influence the decisions affecting them.

Most of the factors related to the bureaucratic structure and management style of the senior people in the department were perceived as not influencing the instructional planning decisions of the nurse-academics in this study. Table 5 shows the full results for the cluster 'Bureaucracy'.

The structure itself was perceived by about one-third of the respondents (37%) as constraining. Communication patterns were also perceived as constraining by almost half (43%). A cross-tabulation showed no relationship between communication patterns in the nursing department and size of college, geography of college, or whether the college was visited by the researcher.

A cross-correlation showed that the respondents' scores on the cluster 'Governance and Bureaucracy' were fairly strongly correlated with their scores on the cluster 'Bureaucracy' of the Nursing Department' ($r = 0.7$; $p < 0.001$). This indicates that the respondents who found the bureaucracy of the nursing department constraining also found the governance and bureaucracy of the institution constraining. In comparing the results for the college and nursing department bureaucracies, both were perceived as constraining by about one-third of questionnaire respondents, with slightly more being constrained by the college (39%) than the nursing department (32%). More respondents perceived themselves as not affected by the college governance and bureaucracy (52%) than the nursing department bureaucracy (43%). More respondents also perceived themselves facilitated by the nursing department bureaucracy (25%) than the college bureaucracy (9%). Thus, the influence of the nursing department bureaucracy was more positive and slightly stronger than that of the college. Although some frame factors emerged, the perceived framing of the bureaucracy at both levels was generally weak.

3.5.2 Nursing Department Staff

The Heads were perceived by the nurse-academics in this study as the most facilitating factor in the nursing department (see Figure 2). A breakdown of the results for the cluster 'Head of Nursing Department' showed that in none of the colleges visited was the Head perceived as constraining instructional planning decisions, while in Colleges B and C, the Heads were perceived as facilitating, perhaps because of their personal popularity with the staff. Table 6 shows the full results for the cluster 'Head of the Nursing Department'.

The majority of respondents perceived the Head's 'philosophy of education' (60%), 'philosophy of nursing' (56%), 'management style' (56%) and 'personality' (50%) to be facilitating. The Heads' opinions tended to be facilitating (46%). About one-third (38%) found 'Decisions already made by the Head' constraining (singleton item). In all colleges, the lecturers found the Heads facilitating, but certain decisions, for example that the form of final assessment for the units must be a multiple choice examination, could constrain the lecturers' planning: 'Instead of ranging widely, you have to pull the lesson in a bit.' (1/66/02). Thus, the Heads' personality, beliefs and management styles mainly facilitated instructional planning, but some of their decisions were perceived as constraining. A cross-correlation showed that there was a fairly strong correlation between respondents' scores on the cluster 'Head' and their scores on the cluster 'Bureaucracy' ($r = 0.8$; $p \leq 0.001$). This finding indicates that those subjects who found the Head constraining also found the bureaucracy constraining.

TABLE 6

The 'Head of Nursing Department' Cluster

(Cronbach a = 0.93)

	Con %	Neut %	Fac %
Whole Scale	22	24	54
Facilitating Factors (49-66%)			
Head's philosophy of education	18	22	60
Head's philosophy of nursing	22	22	56
Management style of Head e.g. democratic	19	25	56
Personality of Head of nursing department	25	25	50
Factors Tending to Facilitate (35-48%)			
Opinions of Head of nursing department	26	28	46

TABLE 7

The Influence of the Nursing Department Staff

(Singleton Items)

	Con %	Neut %	Fac %
Constraining Factors (49-66%)			
Number of staff able to run small groups	53	22	25
Factors Tending to Constrain (35-48%)			
Supply of clinically competent tutors	47	21	32
Non-influential Factors (<35% constrained and <35% facilitated or >48% neutral)			
Management style of deputy head of nursinsg department	18	54	28
Non-nurse-academic nursing department staff	24	47	29
Facilitating Factors (49-66%)			
Working in a teaching team	10	30	60
Lecturer's areas of special expertise	31	12	57
Factors Tending to Facilitate (33-48%)			
My interdependence with other lecturers	24	28	48
Inter-relationships of staff in Nursing Dept	21	32	47
Nursing Department support staff	31	23	46

The other lecturers were perceived as mainly facilitating instructional planning decisions. Table 7 shows the results for the singleton items 'Nursing Department Staff'.

Lecturers' area of special expertise' (57%) and 'Number of staff able to run small groups' (53%) were perceived as facilitating, while 'Inter-relationships of staff in the nursing department' (47%) and lecturers' own status in the nursing department (44%) tended to be facilitating. 'Supply of clinically competent tutors' (47%) tended to be constraining. The support staff, for example typists and laboratory attendants, were also perceived as somewhat (46%) facilitating. A breakdown of the latter item by college showed that the support staff in College B, who helped with teaching resources, and College D, which had numerous support staff, were perceived as facilitating.

The 'Management style of deputy Head of nursing department' (54%) and 'Non-nurse-academic Nursing Department staff' (47%) were seen as not influential.

'Working in a teaching team' was perceived by the majority (60%) of respondents as facilitating their instructional planning decisions, probably because it diminished the workload. A breakdown of the results showed that working in a teaching team was perceived as facilitating by respondents from colleges B and C. The factor 'My interdependence with other lecturers' was seen by almost half (48%) as facilitating their decisions. A related factor was 'Lecturer/tutors' areas of special expertise' which was seen by the majority (57%) as facilitating. Three lecturers perceived working in a teaching team as facilitating and 'information sharing', for example:

> *[We] work in well with one another and we share. We try and cut down on each other's preparation. I prepare for my own tutorials very thoroughly and then I give [the material] to her, and she does the same for me. So, we share and we cut down on preparation and it ensures that we teach the groups the same thing. (5/46/11)*

The later data (1988) showed that most lecturers found the teaching team one of the most facilitating factors for content and strategies, for example:

> *Working with a team, that's been a new thing. With mental health I used to feel like a lone sailor in the early days [of the C.A.E. program]. That would be the main facilitator for me. (8/92/17)*

Thus, working in a teaching team was a facilitating factor. This finding may be related to the system of nursing that the nurse-academics have come through in which they were used to working in teams on the wards in caring for patients, and thus may see working in teams as the norm, and as beneficial.

Of the respondents, almost half (47%) perceived the factor 'Interpersonal relationships of staff in the nursing department' as facilitating their instructional planning decisions; therefore it tended to be a facilitating factor. Respondents in nursing departments in which there were high quality relationships probably perceived them as facilitating. The lecturers reported a mixture of good and bad interpersonal relationships, but in the main, the teaching team relationships were the ones that affected instructional planning decisions. The interpersonal relationships at the individual level were facilitating.

3.5.3 Workload

The workload and its effects emerged as the strongest frame in this study, as the majority (51%) perceived it as a constraint. Almost one-third were not affected while some (15%) were facilitated (see Figure 3).

Table 8 shows the results for the cluster 'Workload'.

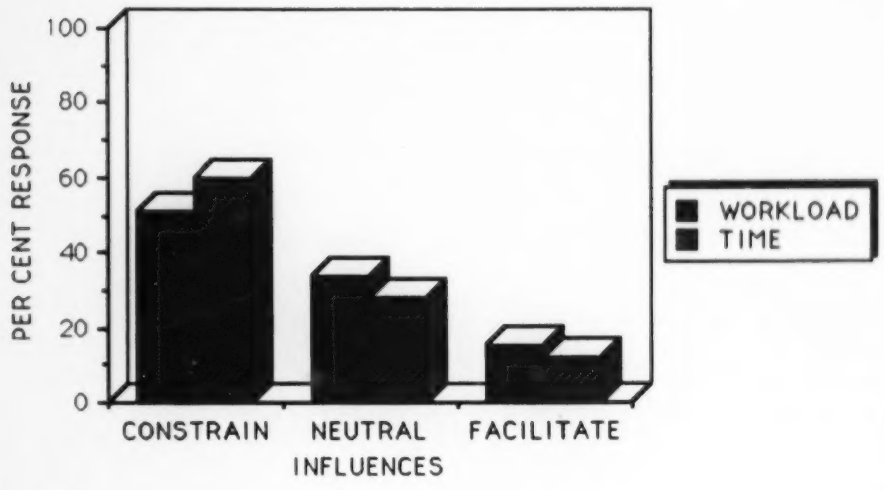

FIGURE 3
Effects of the Workload and Time on Instructional Planning Decisions

TABLE 8
The 'Workload' Cluster

(Cronbach a = 0.88)

	Con %	Neut %	Fac %
Whole Scale	51	34	15
Factors Constraining Most Subjects (>66%)			
Time taken up by meetings	71	22	07
Constraining Factors (49-66%)			
One's own assessment load	53	35	12
Student/staff ratios for clinical supervision	51	27	22
Factors Tending to Constrain (35-48%)			
One's own clinical teaching load	43	35	22
Own lecture load inside nursing department	41	34	25
Non-influential Factors (<35% constrained and <35% facilitated or >48% neutral)			
One's own nursing laboratory load	25	50	25
One's own tutorial load	34	43	23

Most respondents (71%) perceived themselves constrained by: 'Time taken up by meetings'. The majority perceived themselves constrained by 'Assessment load' (53%) and 'Student/staff ratios for clinical supervision' (51%). Almost half (43%) perceived themselves constrained by 'Clinical teaching load' and 'Lecture load' (41%).

However, half of the respondents were not influenced by 'One's own nursing laboratory load', and almost half were not influenced by their 'Tutorial load' (43%). A breakdown of the results for this cluster by college showed that the respondents in the large Colleges C and D were constrained by the workload, whereas those in Colleges A and B were not. In the larger colleges there was a greater diversity of courses and more students and thus a higher marking load.

On the follow-up visits to the colleges, the nurse-academics were asked for specific information about their workload. These data indicated that the average weekly load of face-to-face teaching in the college, including nursing laboratories, was 11 hours, which was within the accepted 14-16 hours per week norm for lecturers (Cleary, 1986:24; Parsons, 1988:24). The average weekly clinical load was an additional average of eight hours per week; however this tended to occur in weekly blocks of 30 hours and this figure was averaged across the semester of 15 teaching weeks. If clinical teaching was included on a basis of equal value with classroom teaching, the lecturers were working an average of 19 hours per week, which was above the norm for college lecturers. According to Parsons (1988:26) 'the crux of the staff workload problems is believed to be the clinical practice component'.

Some information was acquired from the Federated Council of Academics concerning the workload of nurse-academics in Victorian C.A.E.'s. It appeared that in four Victorian C.A.E's, the nurse-academics were engaged in from 16 to 27 hours per week of student contact, including clinical. These figures are approximate only and as they only represent four C.A.E.'s, should not be generalized.

According to Prosser (1980:2), the academic's workload also includes: preparing lecture notes, handouts, visual aids, assignments and assessment; marking examinations and laboratory tests; counselling and assisting students; course organizational activities; helping junior colleagues; curriculum development; writing publications; attending conferences; self-assessment and conducting research. The average weekly load for meetings, administration and marking for lecturers interviewed in this study was nine hours, and the average time spent in student consultations was three hours. Colleges C and D had slightly higher average workloads than Colleges A and B, perhaps because of the size of the institutions. Lecturers in larger institutions tended to have higher marking loads and more courses to teach in. Thus, both the real and perceived workloads were higher in the larger two colleges.

The estimation of the workload is a complex task which is made more difficult by the imposition of values on different kinds of teaching and by other confounding factors such as numbers of students in the class. According to Parsons (1988:26), the vast majority of institutions that she studied gave equal weighting to each type of teaching hour. Three of the four colleges visited by the researcher did not. They had various ways of calculating the workload that adjusted the figures; however these may not be typical. The formulas used did not count all types of teaching hours as equal, for example, counting one hour of lecture as one-half hour of teaching, undervaluing clinical hours or not counting clinical teaching at all. The fourth college did not make any adjustments to the formula, counting all kinds of teaching as equal. Each college was able to rationalize the adjustments, for example, if the lecturer had previously taught the course, the workload was not as high.

The high teaching load, in addition to developing new courses, participating in the administration of the course, for example as a course co-ordinator, and studying for degrees in their spare time accounts for the feeling of pressure that the nurse-academics were under. The workload also created disillusionment among some of the nurse-academics, for example:

> *The thing that worries me is that we were all believers, we wanted it to happen and some of that strength of conviction is just being eroded by all sorts of factors, but workload is one of them. (8/93/23)*

The data suggest that the nurse-academics in three of the colleges visited, if all teaching is considered equal, were working more hours per week than the norm for college lecturers, but that some colleges, for the purposes of calculating official figures, used formulas that adjusted the value of the different components of the load. It appeared that other departments did not have to make such adjustments.

Twelve lecturers commented on the heavy workload, for example:

> *[The workload] just seems to have escalated. I think there's a real danger inherent in never being able to consolidate and review what you're teaching. I think you're perennially chasing your tail. You never, ever, get a straight eye on what's going on. ... I think it's an overload problem in real terms quantitatively and qualitatively, and... people are getting worn out, burnt out, losing performance. That's what I find worrying, professionally and personally, and I don't know who's getting a fair deal. Perhaps no one. (8/37/04)*

Several lecturers stated that they took work home, particularly marking and lesson planning, to a much greater extent than was common in the hospital training system. The pressure to engage in academic behaviour obviously contributed to the perceived workload.

'Time taken up by meetings' was perceived by most respondents (71%) as a constraint, and thus was a strong frame factor. Seven lecturers interviewed were constrained by this factor, for example:

> *I think a lot of the meetings that occur here are public relations meetings with a lot of people coming in ... and it's expected that we be there to attend. What do you do? I had so much on my plate as it was and then a staff meeting yesterday. (4/60/09)*

Meetings included college committees, nursing department committees, curriculum development committees, unit co-ordination committees, and departmental staff meetings. The later data showed that the nurse-academics spent an average of three hours a week at meetings.

The clinical teaching load was one of the important components of the workload, as earlier stated. Most clinical supervision involved one teacher supervising eight students. This low student:staff ratio made the clinical a very expensive component of the program and was related to the cut in the total number of clinical hours. There was also pressure to increase the ratio because clinical is a very expensive component of the program and because other staff did not understand the rigours of clinical teaching. The nurse-academics felt that patient safety and the production of a 'safe' nurse demanded a low ratio. A higher ratio would have affected instructional planning decisions. The increased numbers of students per teacher to supervise in the clinical area affected the strategies chosen and the relations with the ward staff:

> *Out in the clinical in first year, it's still supposed to be a ratio of one educator to six students, who supervise those students all the time, but every week extra students are sneaked in here or there. And what happens is that either the ward staff complain and refuse to have the educator there with that number of students again, or the students are buddied with another student so they don't get the experience. (14/96/06)*

The nurse-academics in this study found the workload a major constraint on planning learning experiences. A cross-correlation showed that there was a fairly strong correlation between the respondents' scores on the cluster 'Workload' and the cluster 'Time' ($r = 0.8$; $p \leq 0.001$), indicating that the subjects who found the workload most constraining also found the effects of time most constraining. This finding is not unexpected; however, it illustrates the connection between workload and its effects in terms of time.

One major effect of the workload was that it reduced the time available for planning learning experiences for the students. Most nurse-academics felt that they lacked time, for example:

> *If you're going to put [the influences] in a hierarchy, time jumps out in enormous black letters and preparation time and pressure ... and not having the opportunity to refine and consolidate the material, because next week you're on to something different. (8/21/19)*

A majority of nurse-academics felt constrained by a lack of time (see Figure 3). Table 9 shows the results for the cluster 'Time'.

TABLE 9

The 'Time' Cluster

(Cronbach a = 0.84)

	Con %	Neut %	Fac %
Whole Scale	60	28	12
Strong Constraining Factors (>66%)			
Time to plan student learning experiences	71	16	13
Constraining Factors (49-66%)			
Time for own professional reading	63	16	21
Time to revise student learning experiences	58	30	12
Availability of time for own tertiary study	56	25	19
Time to maintain own clinical competence	53	25	22
Factors Tending to Constrain (35-48%)			
Availability of time for student consults	35	33	32

Most nurse-academics (71%) felt constrained by 'Time to plan student learning experiences', while a majority (63%) felt constrained by 'Availability of time for professional reading', 'Time to revise student learning experiences' (58%), 'Availability of time for own tertiary study' (56%) and 'Time to maintain own clinical competence' (53%). About one-third of the respondents (35%) felt constrained by 'Availability of time for consulting with students'. A breakdown of the results of this cluster by college showed that the respondents in all colleges visited by the researcher, except College B which did not apply a formula to adjust the workload, were constrained by the limits of time.

The workload also militated against the nurse-academics' ability to achieve what they felt was expected of them in terms of the appropriate academic behaviour. One respondent included an anonymous letter with a questionnaire which said:

> *Very few of my colleagues seem to have any time to do planning in any meaningful way. Most planning is of an ad hoc nature within a short time prior to a teaching session - mostly survival is enough. To the very limited extent that I have any control in planning learning experiences, there are two influencing factors: the need to avoid further stress to myself as a teacher and the need to avoid adding stress to the students (anon. 1987).*

The lack of time also made it difficult for nurse-academics to engage in their own clinical practice which was important for them to achieve credibility as nurses and to plan lesson content that was relevant and current.

The results of lack of time for planning instruction for the students were identified by several lecturers. Lack of time resulted in not being able to preview videos, discuss tutorial presentations with students and not knowing what material the students had already covered. Thus, the quality of the lesson plan could suffer. Lecturers found themselves planning in a rush and reverting to mental instead of written plans. On a personal level, there were reports that the home life suffered. The house was not cleaned nor the garden weeded. The lecturers suffered from exhaustion. Thus, the perceived heavy workload was a very strong frame factor, with effects on both the quantity and quality of instructional planning.

3.6 Geography, Curriculum and Teaching Resources

The geography of the nursing department, teaching resources and the course structure and curriculum affected nurse-academics' instructional planning decisions (see Figure 4).

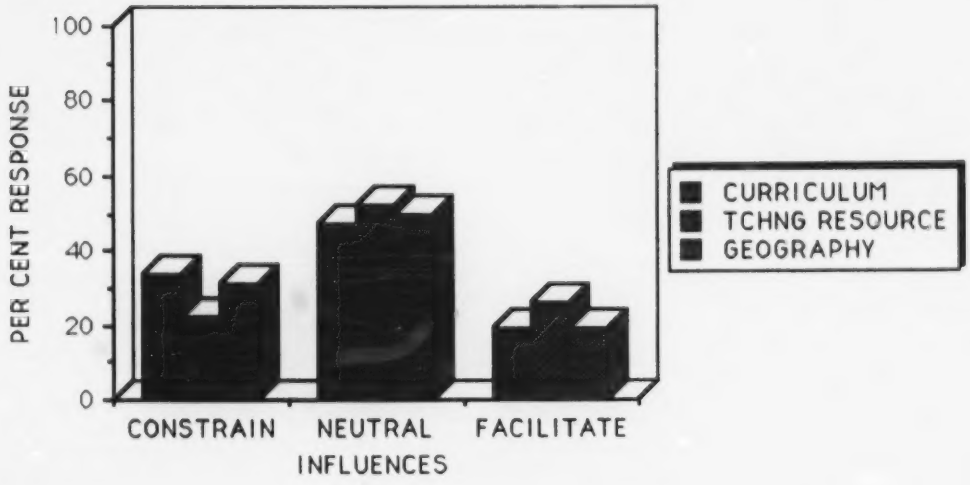

FIGURE 4

Effects of Geography, Curriculum and Teaching Resources on Instructional Planning Decisions

A breakdown of the results for the cluster by college showed that the only college facilitated by the course structure, curriculum and teaching resources was College B, perhaps because it was less complex than the other colleges' structures.

3.6.1 Geography of the Nursing Department

The geography of the nursing department did not affect half of the questionnaire respondents' instructional planning decisions but constrained about one-third (31%) and facilitated one-fifth (19%) (see Figure 4). A breakdown of the cluster by college showed that only respondents from College B, which had a new nursing building with adequate rooms, did not perceive the physical characteristics as constraining. Table 10 shows the results for the cluster 'Geography of the Nursing Department'.

TABLE 10

The 'Geography of the Nursing Department' Cluster

(Cronbach a = 0.87)

	Con %	Neut %	Fac %
Whole Scale	31	50	19
Constraining Factors (49-66%)			
Size of classroom(s)	56	22	22
Factors Tending to Constrain (35-48%)			
Atmosphere of lecture theatre	44	29	27
Sufficiency of space in nursing laboratories	45	27	28
Non-influential Factors (<35% constrained and <35% facilitated or >48% neutral)			
Geographical position of nursing department	23	56	21
Location of lecturers' offices	15	54	31
Location of nursing laboratories	31	50	19
Location of lecture theatres	29	50	21
Geographical layout of nursing department	32	43	25

Analysis of the items in the cluster showed that it was those concerned with the actual geographical layout of the department that did not influence instructional planning decisions. About half of the respondents were not influenced by 'Geographical position of the nursing department' (56%), 'Location of lecturers' offices' (54%), 'Location of nursing laboratories' (50%), 'Location of lecture theatres' (50%), and 'Geographical layout of the nursing department' (43%). However, several constraints emerged. The majority of respondents (56%) were constrained by 'The size of the lecture rooms', while almost half (44%) were constrained by 'Atmosphere of lecture theatre' and by 'The amount of space in the nursing laboratories (45%). It was obviously the properties of the rooms rather than the geographical arrangement and location of the nursing department which were constraints.

A cross-tabulation of the questionnaire data showed that the respondents from Sydney metropolitan colleges were significantly more constrained by the 'Geography of the Nursing Department' than those from non-Sydney metropolitan or country colleges ($p \leq 0.009$). Thus, the size and location of the college affected the nurse-academics' perceptions of the effects of the geography of the nursing department on instructional planning decisions. This finding indicates that the choice of colleges representative of the geographical areas of N.S.W. for the visits was justified.

Twelve lecturers stated that the physical characteristics of the lecture rooms were a constraint on planning learning experiences, for example:

> *I love to use the whiteboard, but in the room we'll be using, you cannot use the whiteboard, because half the class can't see. A major constraint to any teaching strategy you might use is the venue that you have. This is clearly an issue in this place. (8/15/11)*

The physical characteristics of the nursing department mainly affected strategies. For example, had the lecturers wished to break up a large class into smaller groups, the rooms would not have been available, for example:

> *One of the biggest constraints, and it has something to do with bureaucracy, is booking of rooms. It's dreadful, and it really affects planning. I can design the most beautiful plan, and then find I'm in Room X with no overhead projector, no video facilities, no carpet on the floor, ... the geographics are dreadful. (11/55/05)*

(S)he felt that there would be 'lots of other things I would do as far as teaching strategies are concerned if we were in an appropriate environment.' (11/70/16). Lecturers had no choice of lecture room as the timetabling was done centrally. In the later data, seven lecturers found that the physical facilities constrained their strategies, for example:

> *The rooms we have for tutorials. I would like to make some of our tutorials very practically based. In the tutorials in neuro, I would like to have a bed in the room, because I would like to put a student up on the bed and I would like to position them, and for arthritis, and things like that and show them what is a functional joint position. I'd like to have a bed with a traction frame when I talk about fractures. The accommodation is a constraint. (5/90/05)*

Thus, the nurse-academics found the physical characteristics of the nursing department, in terms of features of teaching facilities such as lecture and tutorial rooms, constrained their instructional planning decisions. The physical characteristics of the lecture rooms were the strongest frame factors in the physical characteristics of the nursing department. A cross-correlation showed that the respondents who found the geography of the nursing department constraining also found the teaching resources constraining ($r = 0.7$; $p \leq 0.001$).

3.6.2 Course Structure and Curriculum

In the four colleges visited by the researcher, there was a pattern to the curriculum decision-making structure. Administrative/planning/co-ordinative decisions, for example decisions about deployment of funds, people and teaching resources, were made at the level of the Head of the department with advice from nursing department committees. Once these decisions had been made, the lecturers, working in teaching teams, made decisions about the running of the course units. Individual lesson plans were then developed by the lecturers.

During the setting up of the nursing courses in the C. A. E.'s, the original curricula were developed for submission to the Higher Education Board in the third stage of the process of accreditation. These curricula were approved for implementation at the beginning of the course and until the Stage IV Review five years after the commencement of the course (1989). These submissions usually contained: the academic structure of the college, an overview of the course, the rationale and aims, the subject structure, assessment of student progress, supervision and staffing, the advisory committee, instructional facilities and award, and references to textbooks and resource material. Teaching and learning strategies were usually listed as a 'smorgasbord' of possible strategies for the whole course, for example 'student seminar presentations'. Methods of assessment, likewise, were usually an eclectic assortment. Thus, the document was not prescriptive.

The discussion of the rationale, aims and structure of the course served as the curriculum document. The submission document was being used as the curriculum in all colleges visited at the time of the study. Although some changes had been made, they had not necessarily been formalized in writing a new curriculum. The changes were being compiled for the curriculum *revision in 1988/9 for* the Stage IV Review in 1989. Thus, for the purposes of this study, the submission document was considered to be the formal curriculum.

'Course Structure and Curriculum' was perceived in the main as not influential (47%), as constraining by one-third (34%) and facilitating by one-fifth (19%) ((See Figure 4). Table 11 shows the results for the cluster 'Course Structure/Curriculum'.

TABLE 11
The 'Course Structure/Curriculum' Cluster

(Cronbach a = 0.89)

	Con	Neut	Fac
	%	%	%
Whole Scale	34	47	19
Constraining Factors (49-66%)			
Total time to give content	57	19	24
Total time available for own course unit	53	28	19
Factors Tending to Constrain (35-48%)			
Nursing department class timetables	41	34	25
Integration across units	40	24	36
Control over curriculum change	38	29	33
Factors Tending to Facilitate (35-48%)			
Theoretical framework of the curriculum	21	31	48
% of course that is clinical placement	29	27	44
Placement of unit within course	28	32	40
Curriculum document	27	38	35
Non-influential Factors (<35% constrained and <35% facilitated or >48% neutral)			
Accreditation of the curriculum	12	63	25
Process for changing the curriculum	34	35	41
Pattern of student clinical experience	34	34	32

About one-third of respondents found 'Control over curriculum change' constraining (38%). Unfortunately, this item did not discriminate between the individual's ability to change the curriculum and the control of the process of curriculum change. 'Process for changing the curriculum' tended to be facilitating (41%). A cross-tabulation showed that the respondents' scores on the cluster 'Course Structure and Curriculum' were fairly strongly correlated with their scores on 'Governance and Bureaucracy' of the institution ($r = 0.7$; $p \leq 0.001$) and their scores on the cluster 'Bureaucracy' of the nursing department ($r = 0.8$; $p \leq 0.001$), indicating that those who found the course structure and curriculum constraining also find the governance and bureaucracy of the institution constraining.

About one-third of respondents (35%) were facilitated by 'The curriculum document' while about one-quarter (27%) were constrained. A breakdown of the results for this item showed that respondents from College A were constrained by the document, while those for college B were facilitated, perhaps because the structure of the course was simple. Seven lecturers stated that they were influenced by the curriculum document, for example:

> *Making sure that I cover what's set down in the college curriculum is also an influence. .... Even though there's a lot in that that we should be changing at this time, this is what we've got and you've got to try something before you knock it. We must teach what we've set down. What's the point of having a curriculum if you don't stick to it and you don't try it? (5/22/18)*

As many lecturers paid attention to the curriculum document as did not. Although the content in the curriculum was prescribed, the strategies were not:

> *[The curriculum] obviously outlines the content area being taught in the unit. How I teach it, no, it doesn't because it's nowhere near specific in those sorts of things. (2/58/15)*

Additionally, as the number of hours for each topic was not prescribed, the lecturers were able to put the emphasis where they liked, for example: 'You're left to develop your unit and place your emphasis wherever you see fit, and there's no constraints on you in terms of that.' (5/34/13).

The follow-up data showed that seven of the 11 remaining lecturers did not perceive the curriculum document as a constraint, perhaps because it was non-prescriptive. The major constraint was the number of hours allocated to each unit. The lecturers interviewed had been involved in developing or revising the unit plans since the earlier data collection and had greater experience with them, for example:

> *We thought it right through. We looked at the previous course that was run and we looked at the evaluation forms and we worked it through. We said "They're second year students in a college system. What do they really need to know?" We can't run it like a hospital based program, because you just haven't got the time. You've got to look at what's relevant, what they can take at this level. We cut out a lot of stuff. We don't want students who can read ECG's but don't know how to look after a patient. We want a general nurse who can pick up that the pulse is irregular. (9/93/09)*

This comment shows the practical orientation of the nurse-academics.

The later data showed that the nurse-academics in this study, who now had more experience in the college system, felt less constrained by the curriculum than they had previously:

> *I think the curriculum [last year] did affect me, because I felt I had to stick to everything that it said. But now, because I've gained a lot more experience and know the college better, and know the people better and know how much trust they've placed in me and the responsibility that's put on me to say, "If you think that's okay, well just go ahead and do it."... There is a degree of flexibility as long as it's reasonable. (3/88/13)*

This quotation illustrates the change process that was going on in the development of nurse-academia over time. The researcher noted a general feeling of more confidence among the nurse-academics at the time of the later visits. This feeling of lack of constraint noted above may have come from the confidence that the lecturers had in implementing the curriculum more according to the objectives than the detail of the documents.

The submission document left the nurse-academics a considerable amount of decision-making space, particularly in the area of strategies. The statements of content and objectives also left a reasonable amount of decision-making space. The influence of the curriculum submission on nurse-academics' instructional planning decisions was indirect as it flowed through the lecture and tutorial guidelines developed from the curriculum.

The majority of respondents (63%) found 'Accreditation of the curriculum' did not affect their instructional planning decisions, while 'Pattern of student clinical experience' was also not perceived as influential.

In the colleges it was customary to develop a set of guidelines for students containing a fixed schedule, objectives, content and assessment for lectures, tutorials, and nursing laboratories. These guidelines framed the lecturers from that point, for example:

> *I'm influenced by the objectives (in the unit outline) that I've handed out to the students. Once I've handed out the objectives, I feel that the students have a right to the expectation that I will meet those. (5/22/18)*

The objectives in the guidelines were cited as influences on lesson planning by six lecturers, and the assessment stipulated in the unit outlines distributed to the students was an influence on three lecturers.

Once the guidelines had been distributed to the students, the lecturers did not feel able to alter the sequence, content, or lectures because of the inconvenience to the students. The later data showed that the lecturers were still bound by the schedules once they had been published.

The majority of respondents (53%) were constrained by 'Total time available for own course unit' and 'Total time to give content' (57%). A breakdown of the results for these items showed that lecturers in Colleges A, C, and D were constrained by both of these. Nine lecturers stated that they were constrained by the amount of time to give the content for example:

> *I thought there were unreal expectations to cover those things, there were too many things put into the one tutorial. (9/62/01)*

The perceived lack of time in the new college curricula resulted in part from trying to combine several old hospital courses such as medical-surgical, midwifery, psychiatry and developmental disability. To complete these courses under the hospital system would have required at least six years. Each of these courses had been a basic nursing course leading to registration in its own right. Thus, there were three basic nursing registers: the General, Psychiatric and Developmental Disability registers. Each had a '1000 hour' syllabus, which meant that the total theoretical content for the three courses had been 3000 hours.

When the new college courses were set up in N.S.W., the three divisions of the Nursing Register were changed to one single comprehensive register under the N.S.W. Nurses Registration Act amendment of 1987 (Nurses Registration [Amendment] Act, 1987). The new graduates from the comprehensive nursing programs in N.S.W. were expected to have knowledge and skills in general medical/surgical nursing, developmental disability nursing, psychiatric nursing maternal-infant nursing, paediatric nursing and gerontological nursing. Document analysis of the curriculum submission documents of three of the colleges visited by the researcher showed that the proportion of the curriculum allocated to general and medical-surgical nursing was 60-70% while that allocated to the specialties such as psychiatry, developmental disability, midwifery and paediatrics was 30-40%. The fourth document was impossible to divide along those lines as it was integrated in such a way as to preclude such an analysis. The medical-surgical component of the other three courses predominated in the number of hours; however the number of hours allocated to medical-surgical nursing was still lower than it had been in the old general nursing course.

The compression of material that resulted from the combination of the three basic courses was resented by both the medical surgical nurses and the specialty nurses. The medical-surgical nurses considered their specialty to be the backbone of nursing and resented the time given to 'frills' when they did not have enough hours to teach their own specialty. The specialty nurses were also worried that the students would not get the depth in their specialty because too much time was spent on medical-surgical nursing, for example:

> *The major constraint in the psychiatric teaching in the classroom is the fact that the students will only get two weeks in an institution, some students get one. And I think that's a retrograde step for nursing. (11/30/01)*

Thus there was tension among the two groups. A compounding factor was the advance in technology. This resulted in demands that the nurse master ever-increasing depth of knowledge such as Computer-aided Tomography (CAT) scans and skills such as computer literacy.

When the three-year college courses were set up, the advice from the N.R.B. and H.E.B. on the structure of the new courses encouraged the institutions to aim for 3000 hours for the course, 'a figure not able to be matched by financial resources allocated to them' (Parsons, 1988:25). At the time of the study, the average total course hours were 2,454. This finding was taken from Parsons' data from 20 courses of which approximately half were from interstate (Parsons, 1988:2). In 8 of the 11 N.S.W. institutions studied, the total hours ranged from 1900 to 2400, while in three, they ranged from 2500 to 2900 (Parsons, 1988:5). Thus, many of the colleges reduced their total course hours from the time of the setting up of the course (1984-5) to the time of the study. The clinical hours have been the first casualty in several instances (Parsons, 1988:25). The researcher was present at a meeting in which the staff in one college were informed that the clinical was to be cut by four weeks in the first year. The cuts in clinical were made because of the low teacher:student ratio it demanded, which meant that proportionately more money could be saved by cutting clinical than theoretical hours. Cutting back the first year clinical also offered a greater opportunity for savings as there were proportionately more first year students because of attrition, and the students' inexperience demanded a lower teacher:student ratio. A higher teacher:student ratio manifested itself in such strategies as use of hospital or agency staff to assist with clinical teaching under the supervision of nurse-academics from the college (Parsons, 1988:25).

About half of the questionnaire respondents (44%) felt that the 'Percentage of the course that is clinical placement' facilitated their instructional planning decisions. In the later interviews, after the clinical had been cut in some colleges, the researcher probed the question of the value of the clinical. The quantity and quality of the clinical practicum affect instructional planning decisions in terms of choosing learning strategies.

Many nurse-academics in the later interviews felt that the loss of the clinical meant that it had been eroded. Many also felt that the issue of quality of the clinical was equally important 'Quality rather than quantity' (8/92/21). However, this may have been a rationalization of a change that they were powerless to stop.
The total theoretical hours in the new courses ranged from 924 to 1512, while the total clinical hours ranged from 852 to 1716 (Parsons, 1987:6). Thus, it can be seen that the time available for theoretical teaching in the college courses was less than half of the previous total theoretical hours of the three old courses. Even allowing for the overlap in the three separate courses of subjects in the Life Sciences and Biological Sciences which would be avoided by combining the courses, the time would still be too short.

Additionally, the nursing course at three years was six months shorter than the degree courses for the other paramedical quasi-professions such as orthoptics, physiotherapy, speech pathology and occupational therapy (UCAC, 1988:16). Thus, the nursing course was shorter and at a diploma level instead of a degree. The other English-speaking countries with tertiary nursing courses had a four-year degree course as a preparation for professional practice.

The effect of the shortness of the course was that it affected the strategies used, for example: 'You have to look at different ways of getting the content across.' (1/57/22). Didactic methods, such as the lecture, were considered to be the most efficient method of delivering the content to the students in a short time. Thus, the perceived shortage of time tended to encourage lectures, and also affected the content, for example:

> *I have to choose and cut short because I haven't got enough time to fit everything in. I try as much as possible to deal with the commonest things, but there's no time to extend the students ... to raise their interest sufficiently to make them go and read further about something else. (5/46/01)*

The lack of time also had the effect for another lecturer of choosing to teach by principles rather than content, for example:

> *There's no way that you can do [investigative procedures] in three hours, so you have to decide on a way of getting through the basic principles that would be applicable for all of those procedures, and then do a session on investigatory procedures, so that they know they've got to prepare themselves, prepare their patient, and ask certain questions such as "Is there a particular position that the patient needs to be nursed in?". (12/56/02)*

The follow-up data showed that time to give the content was still considered by nine of the 11 lecturers as a major constraint on content decisions. Lecturers chose the most pragmatic approach:

> *What we do nowadays is we deal with straight up and down clinical psychiatry in the lectures. We started off with a bit more of a humanistic view, being committed to not labelling people and now we find we've got to for better or worse teach straight up and down clinical psychiatry. This is what it looks like, this is the aetiology, course, management. (8/92/09)*

Additionally, the hours referred to in the curriculum seemed to shrink in the implementation:

> *They are supposed to be academic hour lectures. We all thought an academic hour was a full hour and we found it was 45 minutes, so by the time you allow students to get in the hall and you start late and you finish on time, if you're lucky you're looking at 30 minutes' effective teaching time. ... It's a main constraint. (14/96/04)*

Lack of time for the course unit also constrained the choice of strategies that the lecturers used to put across the content. Five lecturers stated that choice of strategies was constrained by a lack of time, for example:

> *You may think you would like to take the student through a problem-solving thing that would be great, to divide them up into groups and to all be able to get to the end in their own time. If you divide them up into too small a group so that they all have to work, then there won't be time to report back. It's so much easier to just stand up and chalk and talk for an hour than to do the more creative things. (12/94/07)*

Also, it affected the depth to which the group could go into things:

> *I think that they would like to spend time in the tutorial asking questions about the lecture and I don't give them the opportunity and the reason that I don't is that I won't get through the work in the tutorial. (5/90/06)*

Thus, the lack of time in the course was a strong frame factor which had major implications for instructional planning decisions.

Of the respondents, almost half (40%) perceived the 'Placement of unit within the course' as facilitating. Three of the lecturers interviewed found the placement of their unit constraining, because they felt that it was too early in the course and the students needed more background knowledge. The placement of the unit in the course therefore could affect the types of learning experiences planned, for example:

> *One of the groups I am teaching won't have had their sensory [nursing laboratory]. '... And I have found that a very big constraint in terms of taking them out on clinical and in terms of the exam that I set. (6/34/07)*

Thus, the placement of the unit in the course was facilitating for some, and constraining for others.

The four colleges visited had different patterns of teaching the domains of nursing, behavioural science and biophysical science, with some taught within the department and some by service departments. Of the respondents, almost half (40%) felt that 'Integration across units' constrained their instructional planning decisions, while about one-third (36%) found that it facilitated them. A Chi square test showed that there was no significant difference for colleges visited, geographical setting or size of college on this item.

One force acting against integration was the communication difficulties resulting from the lack of time resulting from the high workload. Additional factors were the splitting of large departments into sections such as science and nursing, and science subjects being taught by service departments outside the nursing department. Another was the structuring of the program so that the science lectures did not treat topics at the same time as the nursing lectures, for logistical reasons, or because the scientists preferred to follow the logical structure of their discipline, regardless of what sequence the nurses preferred. Thus, it often fell to the nurse-academics to repeat the science and attempt to integrate the material:

> *I integrated it myself, because I asked the students to look up the anatomy and physiology of the heart and lungs, and how they are related, and I go through that before I go into the lecture (material). So, the nursing lecture will be the nurse's role ... and I go through after and say "All right, what will be the after care in terms of the psychological care of the patient as well as the relatives?" ... I found that the students have great difficulty in relating what the three departments teach, unless you give them the overall picture ... they just don't think this way. They don't integrate ... they weren't trained to think that way. (3.38/05)*

The need to integrate the material in the nursing lectures, rather than assuming the students would integrate it, consumed time in the nursing lectures and therefore affected the content of the lectures.

Under the old hospital system, the students were sent on clinical placements that often did not correlate with the theoretical unit they had just had in the classroom. This lack of integration of theory and practice was caused by the service needs of the hospital frequently taking precedence over the educational needs of the students. At the time of data collection for this study (1987-88) there were still problems with achieving integration of theory and practice in the college courses. The colleges had different patterns of clinical practicum, including an integrated one-day-a-week, block clinicals of several weeks in the semester and end-of-year breaks or three weeks theory followed by two weeks practice. The pattern of clinical practice developed was related to the organization of the college academic year. Thus, the three week theoretical component followed by a two week practicum fit into a fifteen week semester. Clinical blocks in some colleges occupied the four week mid-semester break and the end-of-year break.

Although the nurse-academics were not necessarily all working every week in clinical practicum, the mid-semester break was not the same for them as for their colleagues in other departments and the pattern of clinical placement contributed to the effects of the lack of time on instructional planning. A breakdown of the item 'Pattern of clinical practice' showed that, of the colleges visited by the researcher, those with an integrated practicum were more facilitated than those with a block practicum, perhaps because the clinical teaching was more contiguous with the theoretical content.

Some colleges appeared to be abandoning the one-day-a-week integrated practicum, which on the surface would have seemed to be the ideal opportunity to integrate theory with practice. The later data showed, however, that there were problems in making the clinical component contiguous with the theoretical component, particularly in the colleges with large numbers of students. There was a lack of sufficient numbers of appropriate clinical placements for some specialty areas such as psychiatry and maternal/infant health in some areas. There did not appear to be any problem of finding adequate placements for first year students, because the learning was concerned with basic nursing skills that could be learned in a variety of situations, for example nursing homes. There was also less of a problem for colleges that had the clinical practice linked to concepts such as 'need for oxygen', or 'immobility' which could also be learned in a variety of situations. It appeared to be in the very specialized areas that the problem existed. The inadequate numbers of hospital placements were connected with historical forces such as the decreased birth rate and the de-institutionalization of psychiatric patients.

The lack of placements led to adopting alternative learning strategies such as having clinical weeks in the college setting, for example a week of experiential workshopping in the nursing laboratory to prepare the students for the mental health/psychiatry clinical experience, and maternity case studies of expectant mothers in the community, rather than hospital maternity experience. These experiences no doubt have educational value; however the impetus for them appears to have been lack of funds for staffing clinical and lack of clinical placements.

Thus, theory and practice were not completely integrated, although it would appear that they were more integrated than they had been in the hospital system. Given the shortage of hours in the curriculum, integration of material might improve the effective use of the available hours by preventing overlap of content.

In the two larger and one smaller colleges, a clinical co-ordinator had been set up at the beginning of the course to oversee the clinical component and its co-ordination. At the time of the later data collection, the two larger colleges had formed clinical departments, indicating an attempt on the part of these colleges to address the problems of the clinical. In the small college, which did not have a clinical co-ordinator, one had been appointed for the following year (1989). In the other small college, a clinical co-ordinator had been in place, but had left and at the time of writing had not yet been replaced. These appointments were an attempt to improve the quality of the clinical experience, which would affect planning student learning experiences.

The theoretical framework of the curriculum was a facilitating influence on instructional planning decisions. About half of the respondents (48%) found 'Theoretical framework of the curriculum' facilitated their instructional planning decisions.

The curricula of all four colleges had a conceptual framework, for example Orem's conceptual model of nursing, the health-illness and age continua, and a complicated model developed by personnel at one college. Respondents from the college with the complicated model found it constrained their instructional planning decisions. Eight lecturers interviewed were influenced by the conceptual framework of the curriculum in structuring lectures and tutorials, most in a positive way. Thus, the conceptual framework of the curriculum was mainly a facilitating factor.

3.6.3 Teaching Resources

Teaching resources were not a strong influence on nurse-academics' instructional planning decisions, with (see Figure 4). Table 12 shows the results for the cluster 'Teaching Resources'.

TABLE 12
The 'Teaching Resources' Cluster

(Cronbach a = 0.86)

	Con %	Neut %	Fac %
Whole Scale	22	52	26
Factors Tending to Constrain (35-48%)			
System for ordering resources outside dept	41	38	21
Factors Facilitating The Majority of Subjects (49-66%)			
Availability of overhead projector(s)	06	35	59
Adequacy of overhead projector	06	37	57
Adequacy of equipment in lecture rooms	21	29	50
Factors Tending to Facilitate (35-48%)			
Suitability of course textbooks	27	29	44
Non-influential Factors (<35% constrained and <35% facilitated or >48% neutral)			
Supplies of duplicated handouts	29	44	27

Of the questionnaire respondents, almost half (41%) felt that the 'System for ordering resources outside the department' constrained their decisions. A breakdown of the results for that item showed that the respondents from the larger colleges C and D perceived themselves constrained by that system, whereas those from the smaller colleges did not, perhaps because the larger institutions tend to be more bureaucratic. One lecturer commented:

> *It just seems to take a long time to order things and get them because we're not quite so near the major suppliers, and also because often we want things that the hospitals may not have. (1/12/04)*

The majority of respondents found the 'Adequacy of equipment in lecture rooms' (50%), 'Sufficiency of equipment in the lecture room' (52%), 'Availability of overhead projector(s)' (59%) and 'Adequacy of overhead projector' (57%) facilitating. About half of the respondents (44%) found that 'Adequacy of equipment in nursing laboratory' and 'Clinical supplies' (singleton items) facilitated them. For the former item, a breakdown of the results showed that the respondents from College C were again constrained. From the questionnaire data, it would appear that the lecture and tutorial rooms were well enough equipped to be perceived mainly as facilitating. On the whole, the nurse-academics perceived more problems with the adequacy of equipment in the nursing laboratory than in the lecture and tutorial rooms. The problem appeared to relate both to hardware such as demonstration dolls and traction equipment as well as disposable supplies.

About half of the lecturers were constrained by a lack of visual aids, for example:

> *Sometimes something I might like to have used is not available, and therefore I*

feel that I'm constrained because I just have to rely on the verbal or drawing a diagram, where I think the other might have been better. (1/66/04)

Visual aids such as videos had to be ordered in advance from the media resources centre if the department itself did not own them. Visual aids and their availability affected instructional planning decisions, both in terms of structuring content to fit the visual aids, and in terms of strategies, for example:

The lady next door may be wanting to use that when I want to use it. It's not convenient. That problem can be fixed by her using it first and me last, but that will affect the sequencing. (3/38/10)

Thus the lack of visual aids could be a constraint on instructional planning decisions. The hospital schools had had many years to build up considerable quantities of teaching resources, but some colleges were in the beginning stages of developing their collections, so visual aids were sometimes lacking. However, other colleges had bought or rented some of the hospitals' visual aids at the time of the transfer.

Supplies of duplicated handouts were perceived as not influential by almost half (44%) of questionnaire respondents.

Of the respondents, almost half (46%) felt that the 'Efficiency of library in obtaining resources' (a singleton item) facilitated them. The majority (54%) felt that 'Sufficiency of library materials' (a singleton item) constrained them. Apparently the libraries were reasonably efficient at obtaining materials, but still more were needed. The hospital schools of nursing had their own libraries which were usually located in the school and had built up collections over the years. Thus, on moving into the tertiary sector, the nurse-academics had to adjust to the centralized library of the college. Also, there was the expectation of wide reading and keeping up to date that was part of expected academic behaviour.

About half of the respondents (46%) felt that they were facilitated by the 'Suitability of reference texts' (a singleton item). About half (43%), however, were constrained by the 'Availability of reference texts' (a singleton item). The nurse-academics felt that there were suitable reference books, but they were not always available, for example in the library.

About half of the respondents (44%) felt that 'Suitability of recommended course textbooks' facilitated their decisions. Five lecturers were influenced by the textbooks, mainly in planning their content, for example:

In practising mental health, those concepts are used in formulation quite commonly, and some of the texts will refer to them, so we've got to cover them. (8/72/01)

The teaching resources tended to facilitate and therefore left the nurse-academics a considerable decision-making space. The most constraining factors appeared to be those related to acquiring equipment from outside the department, the amount of material in the library, in particular reference books, and equipment in the nursing laboratory. In general, the amount and quality of teaching resources were sufficient so that the latter were not perceived as a major constraint.

3.7 Influence of the Learner

The learner influence was defined as the influences exerted by the learner on the lecturer, either through direct pressure or indirectly through course evaluations and bureaucratic channels. It also includes the characteristics of the pupils. The items on the trial questionnaire that related to the students did not survive the scaling process and therefore were not included on the final questionnaire. Accordingly, there were no questionnaire data for student influences on nurse-academics' instructional planning decisions. However, the researcher decided to investigate the

question of student influence in the interviews, as leaving out the learner frame entirely would have made the document incomplete.

It was customary in nursing courses for the lecturer or unit co-ordinator to distribute course evaluation forms for the students to fill out and return. The information gained from the student evaluations could be used to revise the unit or components of it, for example:

> *I look at whether they felt the objectives were achieved and if not, why not. I look for deficits within the structure and I almost always try and make modifications if things like that come in, like resources. I still believe that my colleagues and I are in the best position to identify what [the students] need to know, so, unless they can put a good case ... if they have a good case, I'm prepared to change, but general whinges because they don't like that area don't influence me. (2/58/05)*

Eight lecturers were influenced by student course evaluations in their planning. As these evaluations were summative rather than formative, the revisions affected the next group of students. Four lecturers took notice of the student evaluations if they agreed with them or if a majority of the students made the same comment.

Eight lecturers stated that they didn't get much direct pressure from students regarding lectures and tutorials, and that it didn't influence them particularly, for example:

> *I don't find students approaching me to change the content or the strategies. I probably have made compromises sometimes as regards assessment, but nothing major. (1/57/13)*

The students apparently tried to influence strategies and assessment rather than objectives or content. Four lecturers stated that they did get some pressure from students.

In the interviews it became clear that student characteristics were an influence. Eleven lecturers stated that student characteristics at entry affected their planning In particular, the students' levels of intelligence and level of knowledge were important:

> *In the basic course, the entry level I assume that they have is a very minimal level of [knowledge of] law. So, we've got to start from the basics and work upwards. It's no good going in there and starting with the 'reasonable man' test when we're looking at negligence. They say "What's that got to do with life?" (13/95/07)*

The age of the students affected planning in terms of strategies, for example:

> *The greatest majority of those that can [learn by objectives] are mature age students who have usually done something else in their life before, and that's why I say I still feel that to expect basic students to go straight out [and learn by objectives] without easing them into it can sometimes put a barrier up, so I just don't do it. (12/56/04)*

Thus, student characteristics were a strong influence on instructional planning decisions.

3.8 The Strongest Constraints

The most important constraints on nurse-academics' instructional planning decisions arose from the set of frames within the institution itself. When the strongest frame factors were taken out of their respective clusters and re-grouped, it became obvious that the most constraining factors (50-75% constrained) were related to time, followed by money (see Table 13).

TABLE 13

The Most Constraining Factors

Factors	% Constrained
Factors Related to Time	
Time taken up by meetings	71
Time to plan student learning experiences	71
Availability of time for own professional reading	63
Time to revise student learning experiences	58
Total time to give content	57
Availability of time for own tertiary study	56
Total time available for own course unit	53
Time to maintain own clinical competence	53
One's own assessment load	53
Factors Related to Money	
Policies on staffing clinical practice	59
Size of classroom(s)	56
Sufficiency of library materials	54
Number of staff able to run small groups in subject area	53
Student/staff ratios for clinical supervision	51
Allocation of funding by college	51

3.9 The Strongest Facilitators

Similarly, the strongest facilitators were taken out of their respective clusters and re-grouped (see Table 14)

TABLE 14
The most Facilitating Factors

Factors	% Facilitated
Head's philosophy of education	60
Head's philosophy of nursing	56
Management style of Head, e.g. democratic	56
Lecturers' areas of special expertise	56
Philosophy of the College	51
Personality of the Head	50

Thus, the strongest facilitators were mainly concerned with the Head, and colleagues.

3.10 Summary: Institutional Influences

The Institutional influences included some constraints. The college influences outside the nursing department were not strong. The governance and bureaucracy and characteristics, history and values were the strongest of the college influences, while policies and regulations were weaker. Funding, however was perceived as a fairly strong frame factor which was linked to most other constraints found in this study. The values of academic behaviour and the status of nursing were also fairly strong frame factors which were linked to the workload.

The nursing department frames proved strongest, with the workload and time which were linked to funding and expectations of academic behaviour. The bureaucracy of the department, which continued the theme of the governance and bureaucracy as somewhat constraining was weaker. The nursing department provided a facilitator in the Head and colleagues.

The geography of the school was constraining in relation to the characteristics of the classrooms but not equipment. The curriculum was a mixed influence, with the lack of time for the course content being perceived as a constraint, but the curriculum documents and process for changing the curriculum being perceived as facilitating. The lack of time for content was reflected in competition for time between the medical-surgical and specialty nursing areas. Lack of integration of theory and practice was an issue linked to funding. The teaching resources were not highly influential, but tended to be perceived as facilitating.

The students did not exert much direct influence on instructional planning decisions. However, student characteristics such as entry levels and age of the students were an influence. Class size was also an influence.

The most facilitating factors related primarily to people, especially the Head and colleagues in the nursing department.

CHAPTER IV

DISCUSSION

4.1 Major Findings

4.1.1 Frames

a) Time and Money

The major constraints which run through this study are related to money in some way. The allocation of money to the nursing course is a higher order frame. The funding of the course has produced some strong constraints such as an increased workload for nurse-academics in some institutions, increasing staff-student ratios for clinical practice, a course which is too short to accomplish its objectives, an ever-increasing diminution of the clinical component of the course, and retention of inferior students to boost the funding of the course. This is an issue which must be solved if nursing is to achieve its educational objectives.

The physical characteristics of the teaching environment were another theme that ran through the findings, with the nurse-academics perceiving the physical characteristics of the college and the nursing department as somewhat constraining. The physical characteristics of the teaching environment are of course linked to funding.

b) The College

The constraint of governance and bureaucracy is another theme that runs through the study with those affected by the governance and bureaucracy of both the higher echelons of the college and of the nursing department perceiving them somewhat constraining rather than facilitating. The management style of the college hierarchy and the policies on staffing clinical practice were perceived as having a tendency to frame decisions, as were the status of nursing and the need for additional qualifications.

The subjects of this study perceived a large decision-making space concerning the college influences, although there were important frame factors and indirect influences emanating from the college and having an impact through the nursing department, for example, funding. The weak framing by the college was perhaps related to the latter's distance from the nurse-academic proceeding through daily activities. Dahllöf found in his study that there were higher order

frames, or those farther up the decision-making hierarchy, and proximal frames, or those lower in the hierarchy. The college frames found in this study are higher order frames. The nursing department, on the other hand, is a more proximal frame with stronger influences, as will be seen in the next section.

The perceived decision-making space of the nurse-academics was seen to be decreased more by the proximal influences such as the workload and less by the higher order influences such as the college outside the nursing department. Thus, the nurse-academics perceived a fairly large decision-making space as far as the college influences were concerned. However, the expectation of academic behaviour, the allocation of funding and the policy on staffing clinical practice were stronger frame factors in that they affected the nurse-academics more directly. The characteristics, history and values of the college were to a certain extent constraining as the expectations of academic behaviour, and the status of nursing were perceived as framing factors.

Thus, about one-third of the nurse-academics in this study were framed by the governance and bureaucracy of the college. The influence was slight, perhaps because the nurse-academics in 1987 had not yet had the time or energy because of the workload to understand the structure of the institution and how it affected their instructional planning decisions.

This study has shown that the nurse-academics in the larger colleges found the constraints linked to the size of the college stronger than those in small colleges because of larger bureaucracies and time spent in travelling on campus. The greatest effect of the institution may be in schools that are large and therefore require extensive co-ordination and control. The finding that the characteristics of larger colleges were more constraining than the smaller colleges is important in view of the policy of the Federal government that smaller colleges must be amalgamated with larger institutions (Dawkins, 1988:44). Care needs to be taken in order to preserve those characteristics of the smaller institution that assist instructional planning.

What is surprising is that the policies and regulations were only perceived as constraining by one-fifth of all respondents. Obviously the nurse-academics perceived a considerable amount of decision-making space concerning policies and regulations. Perhaps the policies and regulations were not perceived as constraining because they were indirect, being implemented via the nursing department, or the ones measured in this study were ones that may not have affected instructional planning decisions. Or, it may be that the nurse-academics, coming from the more circumscribed world of the hospital, where policies and regulations were a part of life, perceived the college policies and regulations as relatively less constraining. The policies and regulations may have more influence at the level of administration/co-ordination decisions and unit planning decisions than on instructional planning decisions. An important exception to the relatively weak effect of policies is that the policy on staffing clinical practice, which was a significant frame factor. The perception of this policy is related to funding, as clinical practice is the most expensive component of the course to staff.

c) The Nursing Department

The workload in the nursing department and its effects were a small, strong frame. The workload was caused by a combination of setting up a new course, inadequate funding for staff, particularly for clinical teaching, and the expectation that nurse-academics would get the appropriate degrees as quickly as possible. This study has shown that not only was the workload perceived as a major influence on instructional planning decisions, but that it had serious effects on the professional activities of nurse-academics such as professional reading, tertiary study and maintaining clinical competence. This issue needs to be resolved so that nurse-academics may become full-fledged academics compete equally for promotion with other academics.

The lack of time for planning affected both the process of planning and the quality of the plan. It may be that this finding reflected the newness of the system of nurse-academia. It was also perhaps a reflection of the workload in real terms in that the workload was thought to be higher than for other academics, involving as it does clinical teaching in which the legal responsibility

and consequently the stress are very great. This problem is likely to be exacerbated by the Federal Government's policy for higher education to decrease staffing levels in the Higher Education sector (Dawkins, 1988:110).

d) The Curriculum

The shortness of the course was a major constraint on instructional planning decisions. There was resulting competition between the medical-surgical and specialty nurses for the time available. The lack of time in the curriculum resulted in a narrowing down of the knowledge taught to the most essential for safe practice. Lack of integration of theory and practice was also a serious problem in the courses, with the clinical component being reduced because of funding, with substitution of simulation for actual clinical experience.

It appears to be virtually impossible to produce in three years a comprehensive nurse who is skilled, even at the level of a first practitioner, in medical-surgical nursing and all the specialty areas. Trying to combine three courses resulted in an overcrowding of material and competition for time in the curriculum. There are three obvious solutions to this problem. The first is to return to separate registers. However, this would probably be seen as a retrograde step in N.S.W. as it would go against the principle of the comprehensive nurse. The second is to reduce psychiatry and developmental disability to an introduction only and make the preparation for professional practice a post-graduate course, such as midwifery. A third solution is to extend the length of the course, an unlikely prospect in this era of reduced funding.

A lack of integration of theory and practice existed in some cases owing to inadequate clinical placements for some specialty nursing areas such as psychiatry and maternal/infant care. The situation was better than it had been in hospital nursing programs because the clinical experience in the college system was independent of the service needs of the hospital. At the time of the study, there was a political climate of ever-reduced funding accompanied by demands for increased productivity. On the other hand, clinical teaching was by far the most costly part of the nursing program because of the low staff/student ratio (1:6 to 1:9) it requires. This is a very important issue in the college nursing course and it is linked very strongly to funding. There is a danger that because of funding cuts the amount of clinical experience in the health care agencies could recede or the ratio of staff to students in the clinical practicum could increase to the extent that clinical teaching becomes merely clinical supervision. There is also the danger that the clinical experience will increasingly be staffed by more poorly qualified and therefore less expensive staff, for example an increase in part-time staff without teaching experience or qualifications. It is also possible that clinical experience in health care agencies could be increasingly replaced by the more economic and convenient alternative of nursing laboratory experience. Although nursing laboratory experience is educationally valuable, it is a preparation for rather than a substitute for the 'real thing'. In order to produce a competent nurse, it is necessary to provide sufficient supervised practice and clinical teaching in the actual nursing situation. Attention must therefore be given to finding ways of coping with this problem without sacrificing the quality of the clinical experience.

e) The Learner

The characteristics of the learners were also a constraint on instructional planning decisions. The age and the H.S.C. levels as indicators of intelligence were frame factors. The attitude of students did not exert an appreciable influence on instructional planning decisions. Hoshiko also did not find the learner a particular influence; rather she found that it was the lecturers' beliefs about the content in connection with what it could do for the learner, for example prepare the learner for the future, which was an influence. Perhaps it is a characteristic of tertiary education that the learner has a more indirect influence. The tertiary education system is concerned with credentialling and getting an education; the lecturers, who are qualified members of the profession, consider that they are the experts on suitable content.

The student entry levels influenced most nurse-academics' planning decisions, in particular their intelligence and levels of knowledge at entry. The entry level for nursing was in many cases

lower than average for other courses and therefore attracted students who performed less well on the H.S.C. Additionally, the funding system militated against eliminating students who were not up to standard. Thus, it is not surprising that the nurse-academics had to take into consideration a lower level of ability than they would have liked. This is an important issue also, for it means that the funding issue may result in a lower quality of health care professional produced. As a consequence, the quality of health care may deteriorate as the nursing profession comprises the largest group of health professionals and a reduction in quality would have a large impact on the system.

4.1.2 Facilitators

This study found that most of the facilitators were linked to colleagues. The nurse-academics perceived the Head as strongly facilitating and the faculty as facilitating, particularly those they worked with in teaching teams. This finding points to the importance of careful selection of Heads for interpersonal skills and careful teaming of nurse-academics in teaching teams. Thus, colleagues significantly increase the decision-making space of nurse-academics. Other findings on clinical nurses as facilitators may be found in Roberts (1990).

4.1.3 Factors That Do Not Influence

This study has shown that there was many factors which were perceived as not influencing the nurse-academics' instructional planning decisions. These were mainly in the area of the college; most of the college governance and bureaucracy, characteristics, values, policies and regulations. It is possible that these factors were influential, but indirectly, through the Nursing Department.

4.2 Relationship of This Study to Other Studies

The findings of this study agreed with those of Hoshiko (1988:45) concerning the influence of the following: the faculty, the learner and lack of time in the course. The findings of this study concerning the aims of the institution, teaching resources, and the curriculum document, did not support Hoshiko. Hoshiko, however, was measuring influences on content decisions only, while this study measured influences on strategies as well. Hoshiko's system was not in the same transition as the system of nursing education in Australia. Hoshiko's subjects were prepared at a much higher academic level than those in this study as 80% of her subjects had master's degrees. A discussion of the relationship of the findings of this study to the general education literature can be found in Roberts (1989). The results of this study have not been related to the theory-generating studies because the latter are mainly concerned with interactive decision-making. However, this study does confirm the theory that there are frame factors which impinge on instructional planning decisions such as physical characteristics, administrative decisions and recommendations about content postulated by Dahllöf (1978) and the composition of the class (Lundgren, 1972), and suggests that these factors are common to both planning and interactive decisions.

4.3 Generalizing the Findings of the Study

The lack of difference in the scores on the questionnaires from different department sections indicates that the findings of this study are generally valid for nurse-academics in New South Wales. Although the interview data were taken only from nurse-academics working in the Nursing and Health sections of the four colleges visited, and not Life Sciences or Behavioural Sciences, the finding that the interviewees were not significantly different from the rest of the questionnaire sample on their responses to the questionnaire indicates that the interview data may well apply to those other nurse-academics. The finding that the interview data in general agree with the questionnaire data also indicates that the findings of this study can be generalized to all nurse-academics in New South Wales.

The results for the earlier interview data were confined to constraints only. Therefore the findings for the earlier data should only be generalized to constraints.

The findings of this study may have implications for other states. Although the sample was drawn from New South Wales only, the similarity of the nursing system and its historical development across Australia suggests that the nurse-academics in New South Wales would not be very different from nurse-academics in other states.

4.4 Limitations of the Study

The instrument was able to measure the strength of the frames and facilitators only in terms of the percentages of people reporting themselves as affected. It did not account for the individual's perceptions; however the interview data were able to supplement the quantitative data in terms of not only the number of people affected, but the nature of the effect. The instrument was able to measure the strength of the frames and facilitators only, whereas the qualitative data gave indications of both the strength and size of the frames and the strength of the facilitators.

4.5 Theoretical Framework

The theoretical framework for this study was frame factor theory, discussed in Chapter 1. This study has shown that frame factor theory only accounts for some of the influences on the nurse-academic. There is in fact a continuum of influence ranging from strong constraints at the one end to strong facilitators at the other. The facilitators, composed of facilitating factors, are the opposite of frame factors and are manifestly different. There has been a dearth of research on this topic. This study has developed the concept of facilitators and facilitating factors to explain positive influences on curriculum decision-making. The frames and facilitators both have the dimension of strength as measured by the degree that the subjects are affected; however the notion of size is much less applicable to the facilitators except in that they enlarge the decision-making space. The author therefore proposes facilitating factor theory to account for the positive influence of facilitating factors on curriculum decision-making. This theory development has extended the concept of decision-making space explored by Smith (1984). In the case of facilitators, the decision-making space is opened up rather than diminished as it is by frames.

4.6 Strengths of the Study

By using a random sample of all of the nurse academics in New South Wales for the questionnaire, the study insured a reasonable level of external validity. Selecting colleges representative of size and geographical location also ensured a degree of external validity. Also, because the study used an interview sample representative of the nursing department in terms of section, gender, and type of subject taught, the results for the interview sample could be generalized. Restricting the sample to those with at least one year's experience in the institution also ensured the subjects' familiarity with environment and increased internal validity.

The face validity of the questionnaire was enhanced by deriving the items from the literature and from issues arising from the pilot study. It was also increased by having the questionnaire vetted by expert nurse-academics in positions of authority. The alpha co-efficients for the clusters and the good return rates also helped ensure the validity of the findings.

The use of triangulation or multiple methods of data collection helped to ensure internal validity. In the main, the questionnaire and interview data supported each other which argues for the validity of the findings and for the value of triangulation in educational research.

This study has gone beyond the mere investigation of relationships between variables inherent in the logical-positivist research paradigm. Through the use of interviews it has revealed

problems that arose from the transfer of nursing education to the tertiary sector. Some of these problems require urgent attention. Recommendations are proposed in the next section.

4.7 Recommendations Arising from the Study

4.7.1 Recommendations to the Government

One of the major findings of this study was that the nursing course is too short to achieve its goal of the production of the comprehensive nurse. Therefore it is recommended that:

1. **The true cost of nursing courses is investigated and the funding is made commensurate with the cost.**

2. **The basic nursing course is lengthened to at least three and one-half years.**

and/or

3. **The preparation for professional practice in psychiatric and developmental disability nursing takes place at the post-graduate level.**

4.7.2 Recommendations to Heads

This study has highlighted several problems that are present in the college system of nursing education. The following recommendations are made concerning these problems. It is recognized that it may not be within the power of the Heads to resolve all the dilemmas that this study has demonstrated. These problems are pervasive and call for concerted action by the Heads who as a group could study these issues and exert political action to achieve these aims.

It is recommended that nursing departments in colleges of advanced education take the following actions:

1. **Find ways to improve the use of the time currently available in the course, for example by more integration of theory and practice.**

2. **Increase opportunities for nurse-academics to acquire the appropriate academic qualifications as quickly as is feasible.**

3. **Develop mechanisms for nurse-academics to maintain their clinical expertise.**

4. **Find ways to reduce the workload.**

4.7.3 Recommendations For Further Research

It is recommended that further research be done

a) to advance theory:

1. **continue the development of facilitating factor theory as proposed by Roberts herein.**

2. **continue the development of frame factor theory, in particular the discrepancy between the actual and perceived frame factors.**

b) to collect data relevant to problems and issues raised:

1. **determine what is the appropriate length, level and content for a basic nursing course.**

2. **determine more accurately the workloads of academics in colleges of advanced education.**

3. **determine the most educationally sound ratios for clinical teaching.**

4.8 Significance of the Study

This study has extended the theory of frame factors to explore facilitating factors and to postulate facilitating factor theory. Thus, the concept of decision-making space has been extended, as well. The findings of this study highlighted the factors which facilitate nurse-academics' instructional planning decisions, namely colleagues. These findings are significant because it is just as important to encourage the factors which promote efficiency as it is to avoid the pitfalls. By showing that the interpersonal relationships are important facilitators, this study has highlighted the important role of the Head and the faculty and teaching teams.

This study also was the first to explore influences on instructional planning decisions in higher education institutions in Australia. The tertiary sector is less centralized in Australia than the primary and secondary school systems. Thus, elucidation of the influence of the tertiary context on instructional planning was a significant contribution to the application of frame factor theory.

This study has made a significant contribution to the understanding of some aspects of the transition of nurse-education to the tertiary education system. It has shown some of the experiences of the nurse-educators in the process of becoming nurse-academics. It contains information of interest concerning the history of nursing education, and has brought out important issues concerning the process of transferring nursing courses to the tertiary sector.

This study has raised major issues concerning the constraints on the implementation of basic nursing curricula in the tertiary sector such as the inadequate length of the course, the workload and the inadequate classrooms, all of which were related to funding and the inadequacy of the teaching environment. These findings are important as they have highlighted problems that need to be addressed in order to increase the job satisfaction and the productivity of nurse-academics. An understanding of the issues affecting the implementation of nursing curricula is an important pre-requisite to taking action to resolve them.

In joining the mainstream of tertiary education in New South Wales, nursing has taken another step on the journey to professional status. Although a significant milestone on the journey has been passed, the rest of the journey will not necessarily be easy. By documenting the travel diary of nurse-academics on part of that journey, and highlighting the roadblocks and the gateways, this study has contributed to the development of nursing academia in Australia.

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APPENDIX:

QUESTIONNAIRE

INSTITUTIONAL INFLUENCES ON NURSING CURRICULUM DECISIONS

INSTRUCTIONS

The purpose of this questionnaire is to determine the opinions of nurse lecturers about the strength of influences within the institution on decisions they make in implementing their curriculum. In the column on the right, please rate the items according to how they influence your own decisions in planning learning experiences for the students in the basic nursing course.

Code:

1 - Strongly constrains (or inhibits or limits)
2 - Constrains (or inhibits or limits)
3 - Neither constrains(or inhibits or limits) nor facilitates i.e. does not affect
4 - Facilitates
5 - Strongly facilitates

Opportunity to maintain my own clinical competence	1 2 3 4 5
College policies on staff promotion	1 2 3 4 5
Control of college committees	1 2 3 4 5
Allocation of funding to nursing by college	1 2 3 4 5
My own autonomy as a nurse lecturer	1 2 3 4 5
Location of lecturers' offices in nursing dept.	1 2 3 4 5
Student/staff ratios for clinical supervision	1 2 3 4 5
Power of academics in other departments of the college	1 2 3 4 5
Location of nursing laboratories	1 2 3 4 5
Dean's control of funding of nursing course	1 2 3 4 5
Traditions of the college, e.g. science emphasis	1 2 3 4 5
Competition between faculties in college	1 2 3 4 5
Availability of overhead projector(s)	1 2 3 4 5
College policy on staff doing own clinical practice	1 2 3 4 5
Adequacy of clinical teaching facilities, generally	1 2 3 4 5
Amount of time available for my own professional reading	1 2 3 4 5

Decisions made by Education Committee of college	1 2 3 4 5
Number of staff able to run small groups in subject area	1 2 3 4 5
Access to clinical teaching facilities, generally	1 2 3 4 5
Curriculum document (submission)	1 2 3 4 5
Amount of time for revision of student learning experiences	1 2 3 4 5
Adequacy of equipment in nursing laboratory	1 2 3 4 5
Location of lecture theatres	1 2 3 4 5
Amount of library resources available	1 2 3 4 5
Management style of Nursing Department head e.g. democratic	1 2 3 4 5
Other departments' timetables	1 2 3 4 5
Decisions made by committees of nursing dept.	1 2 3 4 5
Management style of lecturers	1 2 3 4 5
Location of nursing library collection in college	1 2 3 4 5
Supply of clinically competent tutors	1 2 3 4 5
Size of college	1 2 3 4 5
Interaction with academics from other departments	1 2 3 4 5
Deadline for student enrolments	1 2 3 4 5
My own clinical supervision load	1 2 3 4 5
Amount of clinical supplies e.g. dressing packs available	1 2 3 4 5
Geographical layout of Nursing Department	1 2 3 4 5
Accreditation of the curriculum (H.E.B. Stage IV Review)	1 2 3 4 5
Working in a teaching team	1 2 3 4 5
Efficiency of library in obtaining resources	1 2 3 4 5
College regulations on co-requisites	1 2 3 4 5
Method of assignment of teaching load in Nursing Department	1 2 3 4 5
College's values, e.g. emphasis on science	1 2 3 4 5
Degree of centralization of the college administration	1 2 3 4 5
Status of Nursing within the college	1 2 3 4 5
Total time available for my own course unit/strand	1 2 3 4 5
Availability of suitable outside lecturers	1 2 3 4 5
Prestige of the college	1 2 3 4 5
Time taken up by meetings	1 2 3 4 5
Philosophy of the college	1 2 3 4 5
College policy on year-long or semester progression	1 2 3 4 5
Decisions made by Council of the college	1 2 3 4 5
College policies on equal opportunity	1 2 3 4 5
Power of the Principal of the college	1 2 3 4 5
My own lecture load inside Nursing Department	1 2 3 4 5
Amount of equipment available in nursing laboratory	1 2 3 4 5
Adequacy of overhead projector	1 2 3 4 5
College regulations on pre-requisites	1 2 3 4 5
Process for changing the curriculum	1 2 3 4 5
My own nursing laboratory load	1 2 3 4 5
Availability of reference texts	1 2 3 4 5
Placement of unit/strand within course	1 2 3 4 5
Amount of equipment available in lecture rooms	1 2 3 4 5
Atmosphere of lecture theatres	1 2 3 4 5
Size of classroom(s)	1 2 3 4 5
Decisions made by Board of Studies/Faculty (Academic) Board	1 2 3 4 5
Nursing Department class timetables	1 2 3 4 5
Policies on staffing clinical practice	1 2 3 4 5

Policies reflecting legal liability of college	1 2 3 4 5
Attitudes of non-nurse academics	1 2 3 4 5
Communication patterns within Nursing Department	1 2 3 4 5
Amount of time available for consulting with students	1 2 3 4 5
My own tutorial load	1 2 3 4 5
Control over curriculum change	1 2 3 4 5
College administration	1 2 3 4 5
Policies for assessment of student progress	1 2 3 4 5
Policies on exemptions	1 2 3 4 5
Decisions made outside the Nursing Department	1 2 3 4 5
Liaison with other departments	1 2 3 4 5
Total time to give content	1 2 3 4 5
My own assessment load	1 2 3 4 5
Integration of course units with other departments	1 2 3 4 5
Decisions made by committees above Nursing Dept level	1 2 3 4 5
Opinions of Head of Nursing Department	1 2 3 4 5
Management style of college hierarchy	1 2 3 4 5
Theoretical framework of the curriculum	1 2 3 4 5
Amount of space in nursing laboratories	1 2 3 4 5
My interdependence with other lecturers	1 2 3 4 5
Time available to plan student learning experiences	1 2 3 4 5
Adequacy of equipment in lecture rooms	1 2 3 4 5
Suitability of available reference texts	1 2 3 4 5
Allocation of funds within Nursing Department	1 2 3 4 5
Part-time staff for clinical placement	1 2 3 4 5
My own status in Nursing Department	1 2 3 4 5
Patterns of communication with other departments in college	1 2 3 4 5
Inter-relationships of staff in Nursing Department	1 2 3 4 5
Nursing Department policies on student attendance	1 2 3 4 5
College policies for student progression	1 2 3 4 5
Pattern of student clinical experience	1 2 3 4 5
Proportion of course that is clinical placement	1 2 3 4 5
My own clinical teaching load	1 2 3 4 5
Nursing Department policies on student progression	1 2 3 4 5
Policy on making up missed clinical practicum	1 2 3 4 5
System for ordering resources outside department	1 2 3 4 5
Amount of duplicated handouts available	1 2 3 4 5
Suitability of recommended course textbooks	1 2 3 4 5
Size of Nursing Department staff body	1 2 3 4 5
Integration across curriculum units	1 2 3 4 5
Lecturers'/tutors' areas of special expertise	1 2 3 4 5
Head of Nursing Department's philosophy of education	1 2 3 4 5
Adequacy of supply of qualified nurse lecturers	1 2 3 4 5
Management style of Deputy Head of Nursing Department	1 2 3 4 5
Organization of the college academic year	1 2 3 4 5
Nursing Department support staff	1 2 3 4 5
College policy on clinical experience	1 2 3 4 5
Non-nurse academic Nursing Department staff	1 2 3 4 5
Management style of senior lecturers in Nursing Dept	1 2 3 4 5
Decisions already made by the Head of Nursing Dept	1 2 3 4 5
Organizational structure of staff of Nursing Department	1 2 3 4 5
Amount of time available for my own tertiary study	1 2 3 4 5
Degree of bureaucracy in Nursing Department	1 2 3 4 5

Head of Nursing Department's philosophy of nursing	1 2 3 4 5
Personality of Head of Nursing Department	1 2 3 4 5
Nursing Department administration	1 2 3 4 5
Amount of time available to maintain my clinical competence	1 2 3 4 5
Geographical location of Nursing Department in college	1 2 3 4 5
History of the college	1 2 3 4 5
Organization of the Nursing Department academic year	1 2 3 4 5